

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02517

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02509

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7925 Church Avenue	
3. NAME OF DECEASED (Type or print) Clarence Thomas Allen		4. DATE OF DEATH Month 2 Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1934
9. AGE (In years lost birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard A. Allen		14. MOTHER'S MAIDEN NAME Viola Conter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. -	
17. INFORMANT Howard A Allen Same as 2D		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO and cardiac tamponade (b) From multiple gun shot wounds DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2-12- 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8637 Irving St., Glen Arden, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-13-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-17-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR H S Washington Sons		25a. REC'D BY REGISTRAR FEB 20 1967	
ADDRESS 4925 Deane Ave NE DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs Md.		c. LENGTH OF STAY IN lb 5- Months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side, Maryland		d. STREET ADDRESS 5304- Middleton Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5304- Middleton Lane		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William F. Anderson		4. DATE OF DEATH Month Feb. Day 28th Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15-1870
9. AGE (In years last birthday) yrs. 96		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (County & State, or foreign country) Maryland, Forestville		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Anderson		14. MOTHER'S MAIDEN NAME Mary Vermillion	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Same as	
17. INFORMANT Mrs. Louise Jacobsen (Dau.)		Address # 1.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Cancer of Prostate DUE TO (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-36 , 19 67 , to 2-28 , 19 67 , that (I) (we) last saw the deceased alive on 2-28 19 67 , and that death occurred at 4:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard H. Bobson		22b. DATE SIGNED Feb. 28-67	
22c. PHYSICIAN'S NAME (Type) Richard H. Bobson		22d. ADDRESS Brandywine, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March. 2-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR DATE MAR 2 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Under			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~replace~~ renew carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3-1/2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5006 - 54th Place	
3. NAME OF DECEASED (Type or print) First Middle Last William R. Baxter		4. DATE OF DEATH Month Day Year Feb. 17, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1902
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Baxter		14. MOTHER'S MAIDEN NAME Margaret Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579 22 4819	
17. INFORMANT Dorothy Ann Baxter		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic PANCREATITIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10, 1902 , to Feb. 17, 1967 , that (I) (we) last saw the deceased alive on Feb. 17, 1967 , and that death occurred at 1:55 M. from causes and on the date stated above.			
22a. SIGNATURE <i>Norman D. Cemeau</i>		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Cemeau		22d. ADDRESS 3503 Pennys Mt. Rd. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 20, 1967	23c. NAME OF CEMETERY OR CREMATOR St Mary's catholic	23d. LOCATION (City or Town) (County) (State) Washington D C.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE FEB 20 1967	

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VR A15ME (5)
6M 1/67

02520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02512

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5000 Temple Hill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Anderson Bevard				4. DATE OF DEATH Month Day Year 2 7 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-99		9. AGE (In years last birthday) yrs. 67	10. IF UNDER 1 YEAR Months Days Hours Min. 16-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landover Sand & Gravel Co.,		10b. KIND OF BUSINESS OR INDUSTRY Landover Sand & Gravel Co.,		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard W. Bevard				14. MOTHER'S MAIDEN NAME Elizabeth A. Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 10 7799		17. INFORMANT Address Evelyn A. Bevard Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, (over 6 years)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				22. DATE SIGNED 2-7-67			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10-1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC				25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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Items 18-21 File 386 2-27-67		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
02521		02514	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Dale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton	
c. LENGTH OF STAY IN 1b 6 hrs.		d. STREET ADDRESS Apt. 663	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Private driveway off Glen Dale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Beverly J Bird		4. DATE OF DEATH Month Day Year 2 13 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3 April 1929
9. AGE (In years last birthday) 37 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor S. Mussawri		14. MOTHER'S MAIDEN NAME Harriet L. Gaddis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Harriet L. Mussawri		Address 1319 Stockton Ct. Indianapolis Ind.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Combined intoxication - ethyl alcohol and carbon monoxide DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran hose from exhaust pipe to interior of car	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2-13 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Driveway of Box 138, Glendale P.G. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 2-14-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-15-67	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300 4th St..N.E.Wash., D.C.		25a. REC'D BY REGISTRAR FEB 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d STREET ADDRESS 5202 Tilden Road	
3 NAME OF DECEASED (Type or print) Robert (NMT) Bird		4 DATE OF DEATH Month February Day 6 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 4, 1887
9 AGE (In years, months, days) 79 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10b KIND OF BUSINESS OR INDUSTRY D.C. Government	
11 BIRTHPLACE (State or foreign country) England		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Thomas Bird		14 MOTHER'S MAIDEN NAME Jane Haughton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give power and dates of service) Yes WW I		16 SOCIAL SECURITY NO 220 44 0880	
17 INFORMANT Gertrude Bird Same as #2 (wife)		Address	
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office b.g. etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect and <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 2-7-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md.	
23a BURIAL, CREMATION, or other disposition (Specify) Burial		23b DATE THEREOF 2/8/67	
23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington Arlington Va	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a REC'D BY REG. STRAR DATE FEB 10 1967	
25b REG. STRAR'S SIGNATURE Charles J. Jones			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 13. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

jwb

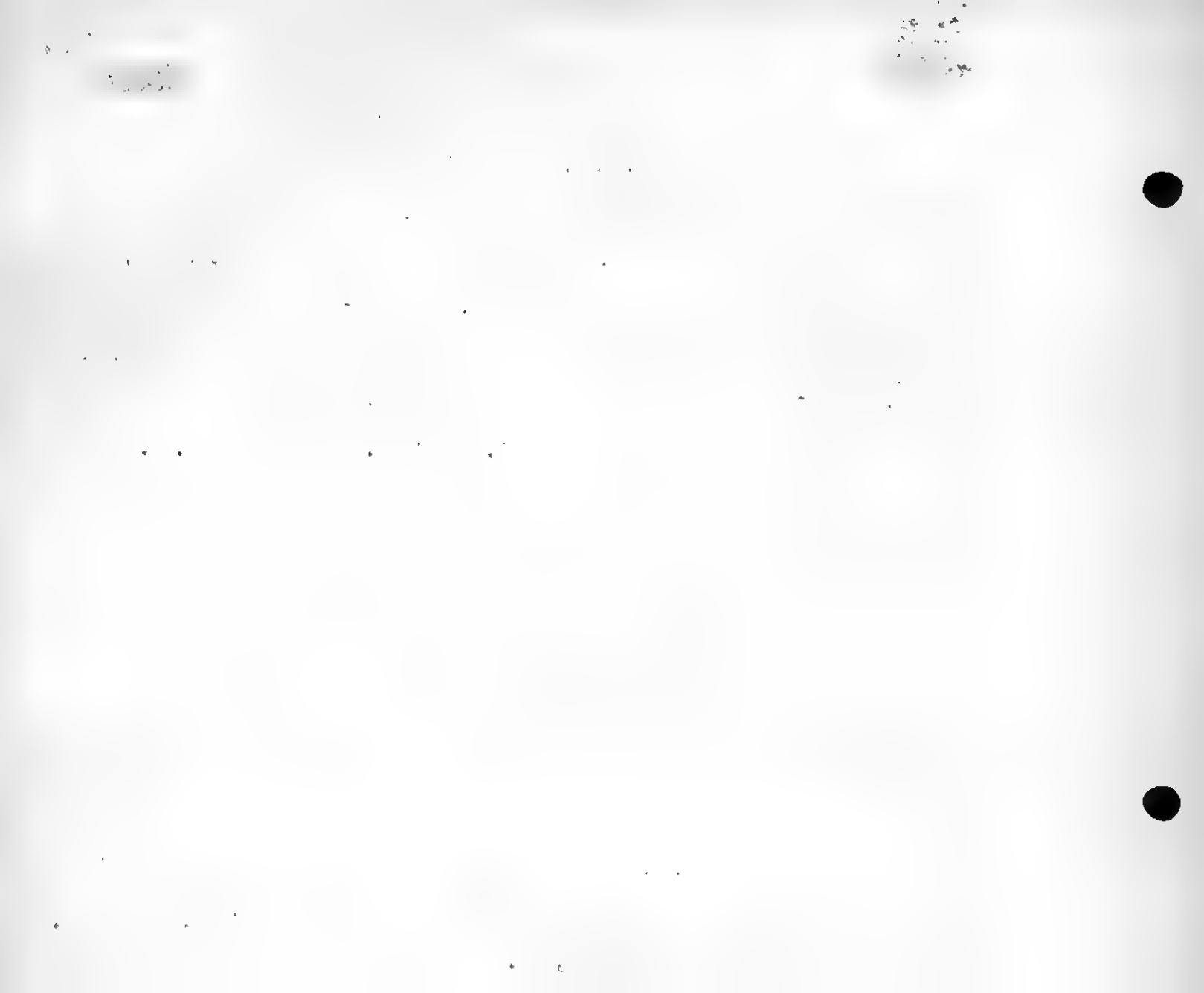
VR A15ME (2)
6M 1/66

02523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02516

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE Maryland b COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b D. O. A.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 6325 64th Street	
3 NAME OF DECEASED (Type or print) JOANNE K. BLACKWELL		4 DATE OF DEATH Month Feb. Day 9 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Oct. 28, 1928
9 AGE (In years birthday) 38 yrs		10 UNDER 1 YEAR Months 1 Days 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technician		10b KIND OF BUSINESS OR INDUSTRY Hospital	
11 BIRTHPLACE (State or foreign country) Texas		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph L. Kirkley		14. MOTHER'S MAIDEN NAME Grace K. Bissel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO no	
17 INFORMANT Cel. Travis L. Blackwell		Address U. S. Army	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication 771.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cyanide ingestion DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drank cyanide solution	
20c TIME OF INJURY Month, Day, Year 6:30 p.m. 2-9 1967	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Riverdale Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 2/9/67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/67	
23c NAME OF CEMETERY OR CREMATORY Blackwell Cemetery		23d LOCATION (City or Town) (County) (State) Taylorsville, Miss.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 14 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE 	



CERTIFICATE OF DEATH

Reg. Dist. No. 02517

02524

1. PLACE OF DEATH a. COUNTY Pr. Geo.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Mem. Hosp.				d. STREET ADDRESS 9012 - 51st Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES		Middle F.J.		Last BROWN		4. DATE OF DEATH Month Feb.		Day 2	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/26/1908		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Supt.		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Timothy J. Brown				14. MOTHER'S MAIDEN NAME Kathleen Flemming					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Mary F. Brown (above address)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 47.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ ACUTE MASSIVE MYOCARDIAL INFARCTION (WIFE) INTERVAL BETWEEN ONSET AND DEATH 3 HOURS								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-2, 1967, to 2-2, 1967, that I last saw the deceased alive on 2-2, 1967, and that death occurred at 2:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3 FEB '67 ACTUAL SIGNATURE C. J. HOUDEMAN M.D. PHYSICIAN'S NAME (Type) C. J. HOUDEMAN DR. JOHN KEGHE RIVERDALE MD									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/4/67		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) Wash., D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home Inc.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02525

Item #14 Film #33-33067

CERTIFICATE OF DEATH

02518

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 507 8th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Samuel First Middle Last Burley		4 DATE OF DEATH Feb. 21 1967 Month Day Year	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 June 1900 9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Burley	
14. MOTHER'S MAIDEN NAME Rebecca Clark		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT John Burley Address Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Insufficiency 163X DUE TO (b) Carcinoma of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (it) (this hospital) attended the deceased from 19 , to 19 , that (it) (we) last saw the deceased alive on 19 , and that death occurred 5:30AM , from causes and on the date stated above			
22a. SIGNATURE Norman K Bohrer M.D.		22b. DATE SIGNED Feb 21, 1967	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M.D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/24/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Bacoptown Md.
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR Rockville Md. 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their office remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>02526</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02519</p> </div> </div>												
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Madison Manor Nursing Home						d. STREET ADDRESS 2604 Colebrooke Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GRACE Middle A Last CAMPER			4. DATE OF DEATH Month 2 Day 3 Year 1967			5. SEX female			6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/18, 1885			9. AGE (In years last birthday) 81 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Frank P. Davis			14. MOTHER'S MAIDEN NAME Emma J. Barlow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			17. INFORMANT Charles C. Camper			Address -2604 Colebrooke Dr. Hillcrest Hts., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 to 2-3 , 19 67 , that (I) (we) last saw the deceased alive on 2-2 , 19 67 , and that death occurred at M , from the causes and on the date stated above.												
22a. SIGNATURE Donald C. Edgren						22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN			
22d. ADDRESS Hyattsville, Md.						22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/6/67		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City, town or county) (State) Washington, D. C.				
24. FUNERAL DIRECTOR The S. H. Hines Co. Washington, D. C.						25a. REC'D BY REGISTRAR FEB 6 1967		25b. REGISTRAR'S SIGNATURE J. Hines				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02527

CERTIFICATE OF DEATH

02520

1 PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Prince George's County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4317 - 57th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Jacqueline J. Carr Baby Girl 4 DATE OF DEATH Feb. 15, 1967		5 SEX Female 6 COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 3, 1967 9. AGE (In years last birthday) 11 yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - 10b. KIND OF BUSINESS OR INDUSTRY -		11 BIRTHPLACE (County & State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip J. Carr 14. MOTHER'S MAIDEN NAME Elizabeth Kreamer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO - 17. INFORMANT Mr. Phillip J. Carr (above residence)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1967, to Feb. 15, 1967, that (I) (we) last saw the deceased alive on Feb. 15, 1967, and that death occurred at 7:20 M. from causes and on the date stated above.		22a. SIGNATURE John W. Perkins, M.D. 22b. DATE SIGNED 2-15-67 22c. PHYSICIAN'S NAME (Type) John W. Perkins, M.D. 22d. ADDRESS 6201 Riverdale Rd. Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/20/67 23c. NAME OF CEMETERY OR CREMATORY Arl. Nat. Com. 23d. LOCATION (City or Town) (County) (State) Arlington, Va.		24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. 25a. REC'D BY REGISTRAR FEB 23 1967 25b. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

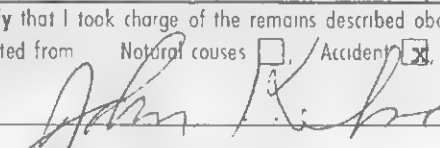

02528

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02521

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e STREET ADDRESS 6705 Oakland Avenue	
3 NAME OF DECEASED (Type or print) Melvin Francis Carroll		4 DATE OF DEATH Month February Day 7 Year 1967	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 6, 1914
9 AGE (in years last birthday) 52 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b KIND OF BUSINESS OR INDUSTRY Distributor	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Bernard Carroll		14 MOTHER'S MAIDEN NAME Dora Roth	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 578 10 7089	
17 INFORMANT Betty E Carroll		Address Riverdale, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Avulsion of medulla and pons DUE TO (b) Fracture-dislocation of atlas DUE TO (c) Conditional: if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Pedestrian struck by car.	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 6:35am 2-7-67 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6700 Block of Good Luck Rd. P.G. Md.	
20f (City or town) (County) (State) P.G. Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 2-7-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb 10, 1967	
23c NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d LOCATION (City or Town) (County) (State) Arlington Virginia	
24 FUNERAL DIRECTOR F. Gasch's Sons		25 ADDRESS Hyattsville, Md.	
25a REC'D BY REGISTRAR DATE FEB 14 1967		25b REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4-1222

FEB 16 1967

256 REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02530

CERTIFICATE OF DEATH

02522

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4007 30th Street	
3. NAME OF DECEASED (Type or print) First Middle Last Ryland P Chapman		4. DATE OF DEATH Month Day Year Feb. 17 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Mar., 1897
9 AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired GAO	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Charlestown, W. Va.	
12 CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Eugene M. Chapman	
14. MOTHER'S MAIDEN NAME Clara Tavenner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO 578-32-3230		17 INFORMANT Nellie G. Chapman Address same as above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CORONARY THROMBOSIS ACUTE DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) 2 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 67 , to 2/17 , 19 67 , that (I) (we) last saw the deceased alive on 2/17 , 19 67 , and that death occurred at 10:45 PM from causes and on the date stated above			
22a. SIGNATURE Norman D. Comeau M.D.		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Comeau		22d. ADDRESS 3503 Penny St Mt Airie Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/20/67	23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	23d. LOCATION (City or Town) (County) (State) Martinsburg, W. Virginia
24. FUNERAL DIRECTOR The S.H. Hines Co ADDRESS 2901 14th St. N. W.		25a. REC'D BY REGISTRAR FEB 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

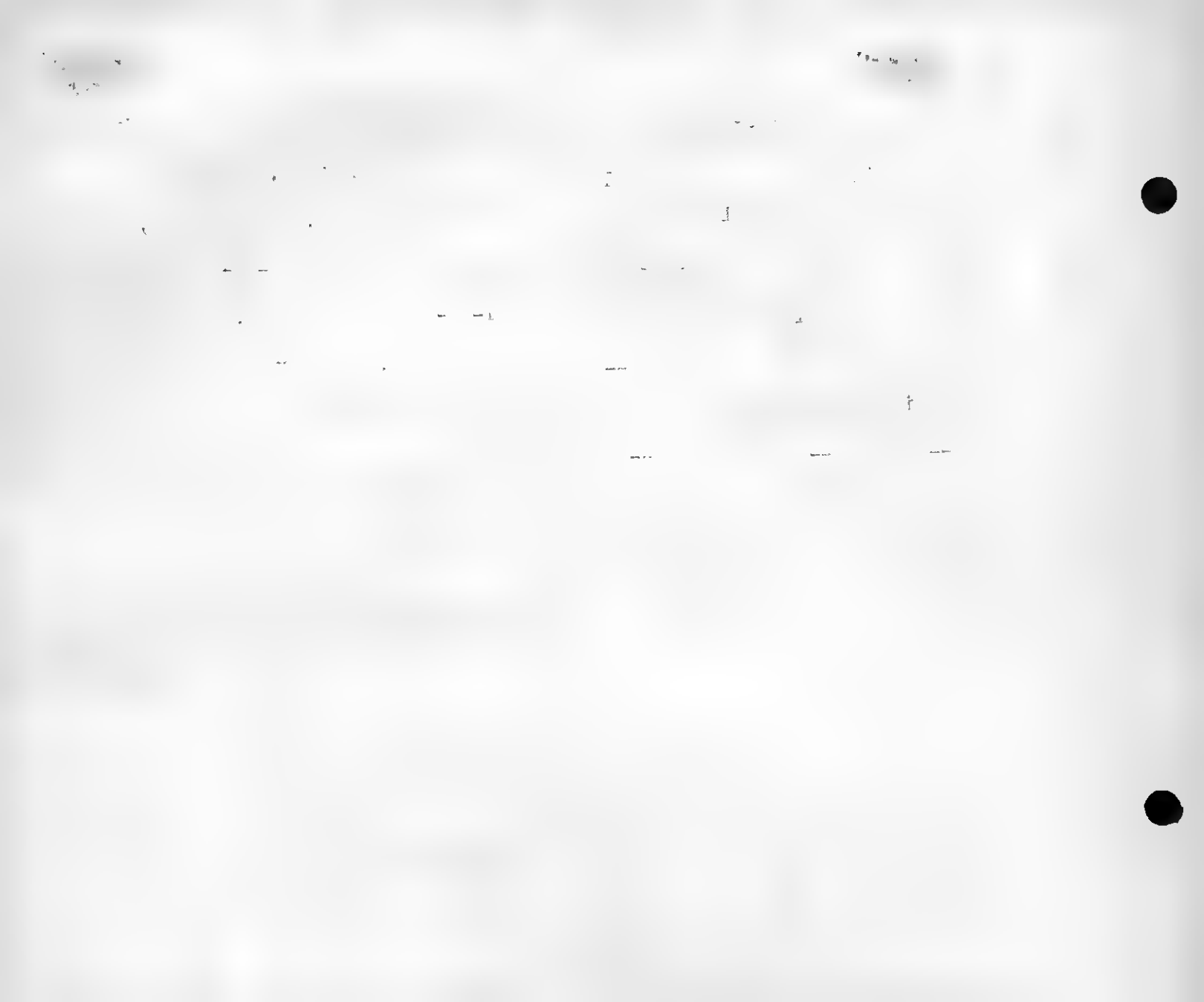
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02531

CERTIFICATE OF DEATH

02524

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,		c. LENGTH OF STAY IN 1b 1 mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland	
f. STREET ADDRESS 3202 Toledo Pl. Hyattsville, Md		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Reynolds Cockran		4. DATE OF DEATH Month 2 Day 17 Year 67	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-67
9. AGE (In years last birthday) 100 yrs		10. IF UNDER 1 YEAR Months 1 Days 7 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Cheseverly, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Henry Cockran		14. MOTHER'S MAIDEN NAME Carol Greenlee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT Father		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 500X IMMEDIATE CAUSE (a) Acute Bacteraemia DUE TO (b) Acute Tracheo Bronchitis DUE TO (c) 24 hrs		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 16, 1967 to Feb 17, 1967 that (I) (we) last saw the deceased alive on Feb 17, 1967 , and that death occurred at 4 PM , from causes and on the date stated above.			
22a. SIGNATURE L.W. Martin		22b. DATE SIGNED 	
22c. PHYSICIAN'S NAME (Type) L.W. Martin M.D.		22d. ADDRESS Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR 	
25b. REGISTRAR'S SIGNATURE 		DATE FEB 23 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02532

CERTIFICATE OF DEATH

02525

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hanover</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>#157 Chesapeake Court</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Heland Memorial Hosp</u>		d. STREET ADDRESS <u>Hanover</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN ALBERT COLLARD</u>		4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9 1916</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>John A. Collard</u>		14. MOTHER'S MAIDEN NAME <u>Tancy Maaney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>John A. Collard</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Pneumonia</u> DUE TO (b) <u>Severe Mixed Atherosclerosis due to</u> DUE TO (c) <u>Arteriosclerotic Hypertension (Viral)</u>		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Baltimore Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 21</u> , 19 <u>67</u> to <u>Dec 21</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>67</u> and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Paul H. Jones</u>		22b. DATE SIGNED <u>Dec 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. H. Jones</u>		22d. ADDRESS <u>Hanover</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>Dr. W. H. Jones</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 1 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02533

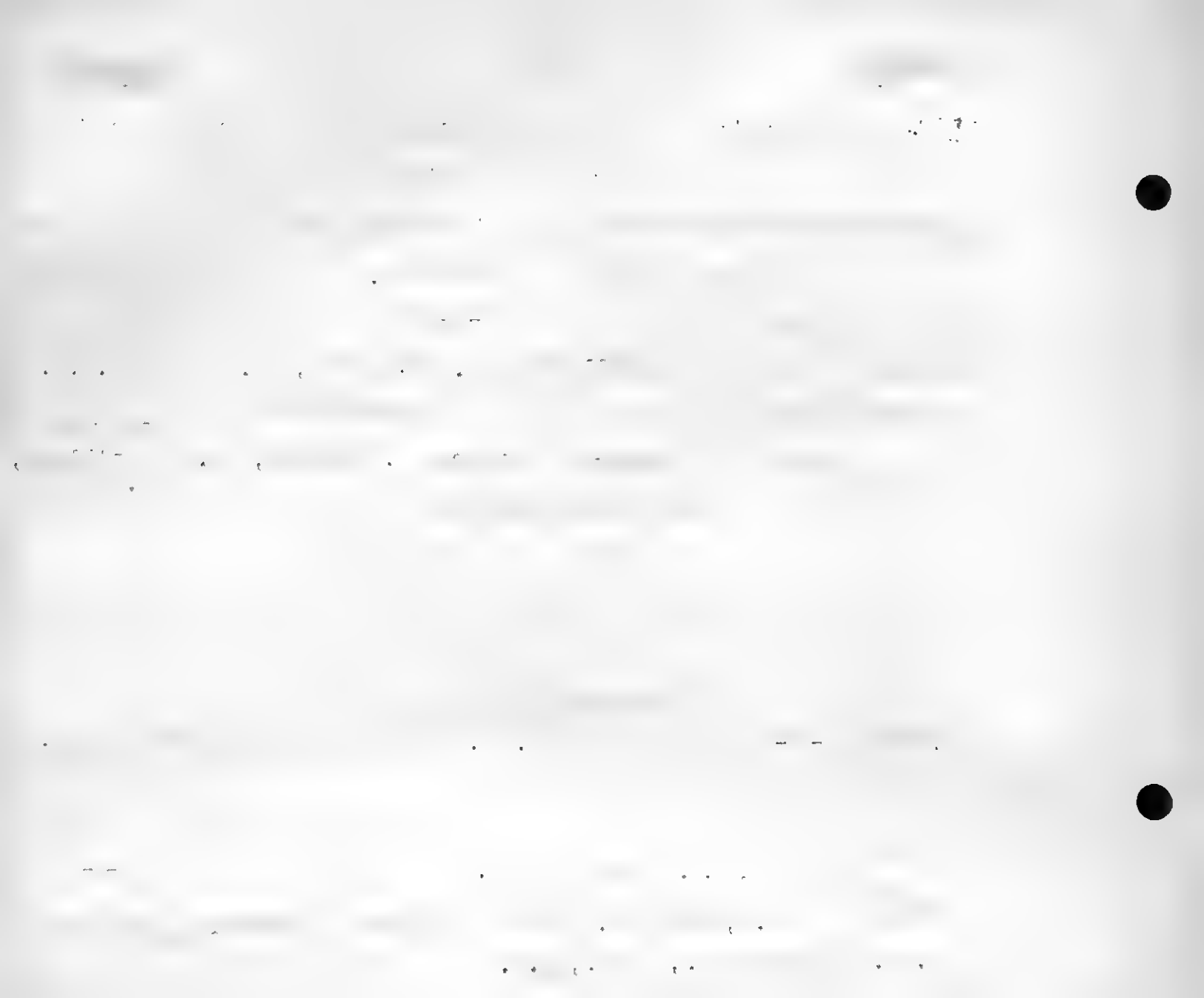
02526

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				d. STREET ADDRESS 7214 Forest Road		e. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Carlin Eugene Coppage Sr.				4 DATE OF DEATH Month 2 Day 28 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1911	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months 28 Days 19 Hours 67 Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Campbell Sand Co.		11. BIRTHPLACE (State or foreign country) Stafford, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Coppage				14. MOTHER'S MAIDEN NAME Mattie Heflin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address 7214 Forest Frances A. Coppage, Rd. Kentville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple skull fractures DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						19. INTERVAL BETWEEN ONSET AND DEATH Mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Run over by truck							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Run over by truck					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:35am 2-28-19 67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) St. Rt. 197, Bowie Pit of Campbell Sand Co.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. MD				22. DATE SIGNED 3-1-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town or county)			
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> BURIAL		23b. DATE THEREOF Mar. 3, 1967		23c. NAME OF CEMETERY OR INTERMENT PLACE Ft. Lincoln Cemetery		23d. LOCATION City or town (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO., Wash., D.C.				25a. RECEIVED BY ATTESTATION DATE MAR 6 1967 Charles Judge			



CERTIFICATE OF DEATH

02534

02527

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Riversdale</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>		c. LENGTH OF STAY IN 1b <u>6 hrs. 45 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Memorial Hospital</u>				d. STREET ADDRESS <u>5409 Emerson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Bruce Alexander Cox</u>				4 DATE OF DEATH Month <u>Feb.</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1890</u>		9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Secretary</u>		11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Cox</u>				14. MOTHER'S MAIDEN NAME <u>Susie Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record, Effie May Cox - (wife)</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO (b) <u>GEN. ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Mos</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>18 DEC.</u> , 19 <u>66</u> , to <u>12 FEB</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>C. J. Houmann</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-13-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				22d. ADDRESS <u>RIVERSDALE MD</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro leo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

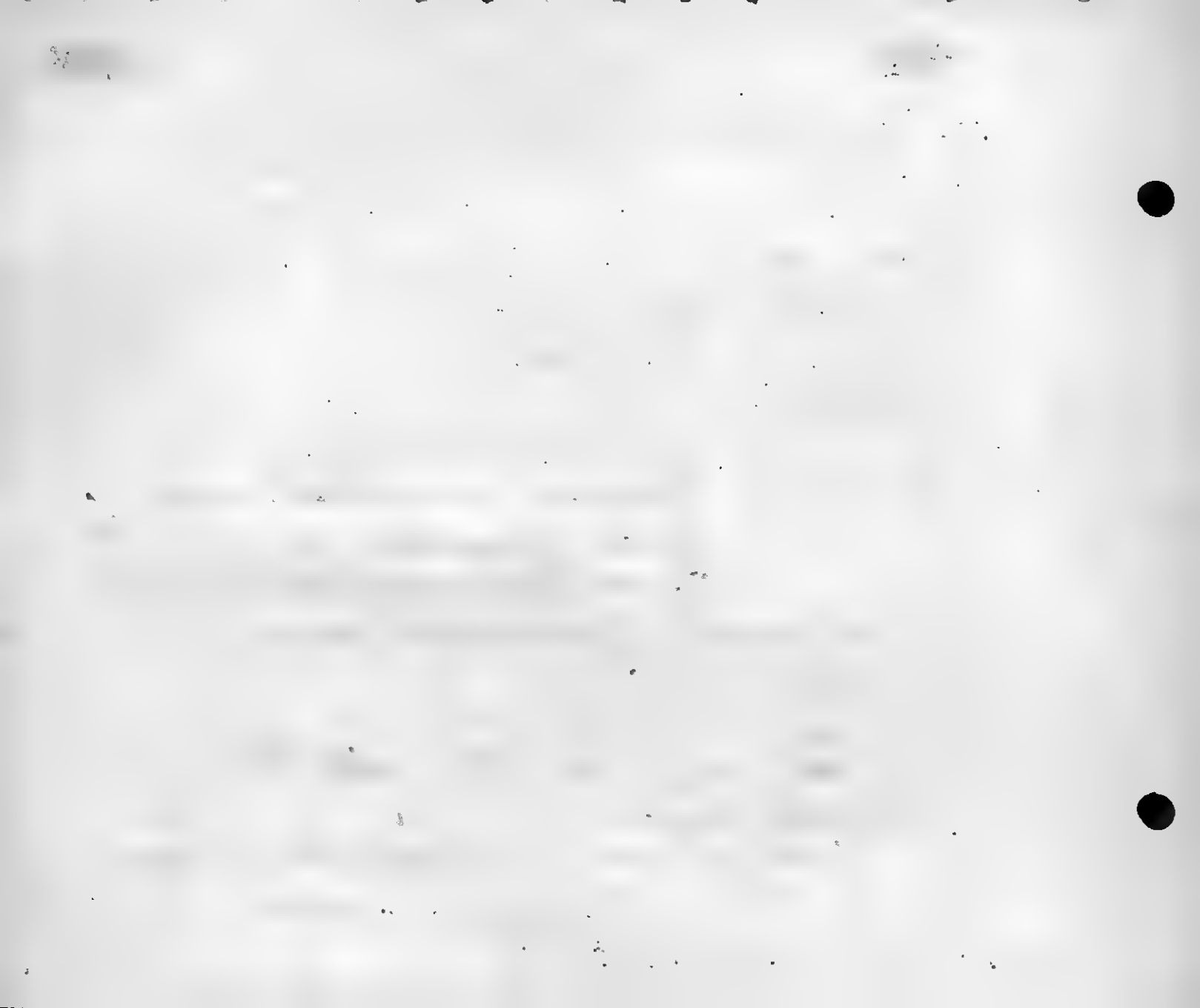
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02535					02528				
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. of C. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home					d. STREET ADDRESS 3500-14th Street, N.W.				
3. NAME OF DECEASED (Type or print) First Middle Last NETTIE I.E. CROCKER					4. DATE OF DEATH Month Day Year FEBRUARY 1, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 13, 1884		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enology		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of Agric.		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Henry Williams				14. MOTHER'S MAIDEN NAME Marion Caroline Luchinger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-52-6577		17. INFORMANT Dorothy S. Jessup			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme Dehydration - Malnutrition (c) Cerebral Thrombosis & bilateral hemorrhage PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from May 12, 1966, to Feb 1, 1967, that (1) (we) last saw the deceased alive on Feb 1, 1967, and that death occurred at 5:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Wilford D. Meyers						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb 1, 1967	
22c. PHYSICIAN'S NAME (Type) Wilford D. Meyers M.D.						22d. ADDRESS 8323 Haddon Dr Takoma Park Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Cremation		2/2/1967		St. Lincoln Cemetery		Prince Georges Co. Md.			
24. FUNERAL DIRECTOR Arthur Walters						25a. REC'D BY REGISTRAR Charles Dwyer		25b. REGISTRAR'S SIGNATURE Charles Dwyer	
DATE 3 1967									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02536

CERTIFICATE OF DEATH

02529

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT HEIGHTS, MARYLAND</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3101 Brewton Drive</u>				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16-1 DISTRICT HEIGHTS, MARYLAND</u> d. STREET ADDRESS <u>3101 BREWTON DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>CYRIL</u> Last <u>DALEY</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>26</u> Year <u>1967</u>					
5 SEX <u>M</u>		6. COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>JULY 27, 1904</u>		9 AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR GAS STATION</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11 BIRTHPLACE (County & State, or foreign country) <u>SAVANNAH, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>LUKE DALEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>JOHN C. DALEY</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> (b) <u>RUPTURED AORTIC ANEURYSM</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from _____, 1958, to FEB 26, 1967, that (I) (we) last saw the deceased alive on FEB 25, 1967, and that death occurred at 2:24 AM, from causes and on the date stated above									
22a. SIGNATURE <u>BENJAMIN S. PELSOW</u>				22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN S. PELSOW M.D.</u>		22d. ADDRESS <u>6106 OLD SILVER HILL ROAD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-1-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>			
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home 4308 Suitland Rd</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATE ON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02537

CERTIFICATE OF DEATH

02538

1 PLACE OF DEATH a. COUNTY Pine View Gardens Health Care Pr. Geo. Center, Inc. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill Camp Springs 3 weeks		c. LENGTH OF STAY IN 1b Oxon Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center, Inc.		e. STREET ADDRESS 251 Audrey Lane XXXXXXX XXX 7401 Stuart Lane	
3 NAME OF DECEASED (Type or print) First Middle Last Lizabelle T. Damron		4. DATE OF DEATH Month Day Year 2 23 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-90
9 AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph A. Turner		14. MOTHER'S MAIDEN NAME Elizabeth Baden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-68-7788	
17. INFORMANT Frank Richard Damron		Address Same as # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE P. T. Turner		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LIPPIN		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-27-1967	23c. NAME OF CEMETERY OR CREMATORY Woods Hill	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR'S Mallory 131-1111 S.E. D.C.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
25b. REGISTRAR'S SIGNATURE John Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MIDDLE STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
02538						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						02531	
1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westwood							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital						d. STREET ADDRESS Nelson-Perry Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ronald Anthony Davis						4. DATE OF DEATH Month Day Year February 4 19 67							
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 26, 1968		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min 4 9		IF UNDER 24 HRS Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George Co. Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James S. Barber						14. MOTHER'S MAIDEN NAME Louise R. Davis							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Louise Barber Westwood, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitital pneumonitis SIX DUE TO (b) SDII Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 2-4-67					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				Address (Street and town, County) Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-7-67		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery				23d. LOCATION (City or town) (County) (State) Malden, Ches. Co. Md.					
24. FUNERAL DIRECTOR Martell Adams Aguasco, Md.				ADDRESS				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			
				DATE FEB 14 1967									

02539

CERTIFICATE OF DEATH

02532

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>17 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDLY</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hospital</u>		d. STREET ADDRESS <u>5226 THOMAS RD</u>	
3. NAME OF DECEASED (Type or print) First <u>ELWOOD</u> Middle <u>T</u> Last <u>DAY</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-24</u>
9 AGE (In years lost theory) <u>43</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>aircraft mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Day</u>	
14. MOTHER'S MAIDEN NAME <u>Jessie S. Soper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>213-14-2494</u>		17. INFORMANT <u>Carlton Day 800-50th Ave. White's Hotel</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longtime Heart Failure</u> DUE TO <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic generally</u> (c) <u>metastatic generally</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-4</u> , 1967, to <u>2-26</u> , 1967, that (I) (we) lost saw the deceased alive on <u>2-26</u> , 1967, and that death occurred at <u>10:35</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Smithland Prince George's Md.</u>
24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>13-14th St</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02540

CERTIFICATE OF DEATH

02533

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 3725-35th St.	
3. NAME OF DECEASED (Type or print) Mariano DeFrancisci		4. DATE OF DEATH Month Feb. Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/86
10a. LAST OCCUPATION (Give kind of work done during past 12 months, if any) Spooling		10b. KIND OF BUSINESS OR INDUSTRY GROCEER.	9. AGE (In years last birthday) 80 yrs
11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME GAETANO De FRANCISCI		14. MOTHER'S MAIDEN NAME MARIANNA INCARDANO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-9974	
17. INFORMANT COLETTINA De Francisci.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO (b) Cerebral embolus, multiple DUE TO (c) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 18 days 18 days 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/29 , 19 67 , to 2/16 , 19 67 , that (I) (we) last saw the deceased alive on 2/16 , 19 67 , and that death occurred at 8:33 M, from causes and on the date stated above.			
22a. SIGNATURE Norman D. Conneally M.D.		22b. DATE SIGNED 2/16/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Conneally		22d. ADDRESS 3503 Pennys Mt. (Ainien Md.)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombed	23b. DATE THEREOF 21 FEB. 1967	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN MANSION	23d. LOCATION (City or Town) (County) (State) WADENSO. RC MD.
24. FUNERAL DIRECTOR KINARDI FUNERAL HOME - WASH. D.C.		25a. REC'D BY REGISTRAR DATE FEB 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02541

CERTIFICATE OF DEATH

02534

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASH. D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK		c. LENGTH OF STAY IN TB 2 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9400 49th AVE		d. STREET ADDRESS 5925 13th ST NW	
3. NAME OF DECEASED (Type or print) First MARY Middle C Last DIEHL		4. DATE OF DEATH Month FEB Day 17 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 1 Year 1	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFONSA CHEVALIER		14. MOTHER'S MAIDEN NAME ELLEN COLLINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 577-09-31990	
17. INFORMANT WAYNE E. SMITH		Address SAME AS 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral occlusion DUE TO advanced cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic curvature of stomach			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 10, 1965 , to Feb 17, 1967 , that (I) (we) last saw the deceased alive on Feb 15 1967 , and that death occurred at 7:30 PM , from causes and on the date stated above.			
22a. SIGNATURE D.B. Washington		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) D.B. Washington MD		22d. ADDRESS 5802 Ridgefield Rd. Bethesda 14 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB 21 1967	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM	23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.
24. FUNERAL DIRECTOR W.W. CHAMBERS CO		ADDRESS RIVERDALE, MD	
25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

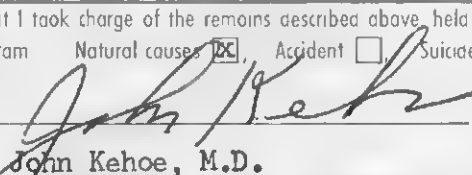

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02535

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 18 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. STREET ADDRESS 1513 59th Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Ann Dooms		4 DATE OF DEATH Month Day Year February 3 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-20-45
9 AGE (In years, last birthday) 21 yrs		10 IF UNDER 1 YEAR Months Days Hours Min. 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Washington D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME George Armstrong		14 MOTHER'S MAIDEN NAME Letitia McGovern	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO	
17 INFORMANT James F. Dooms - husband		Address Same as 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO (b) Rupture of esophageal varix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Portal hypertension Cirrhosis of liver		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days unknown over 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		22 DATE SIGNED 2-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/6/67	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24 FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Road, Suitland Maryland		25a. REC'D BY REG. STRAR DATE FEB 7 1967	
25b. REG. STRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 9,23a Film 3386 3/3/67 mh

02543

CERTIFICATE OF DEATH

02536

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 10 hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Hgts		d. STREET ADDRESS 607 - 60th Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Constance Drew		4. DATE OF DEATH Month Day Year FEB. 23 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/17
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME TOWNSENO LUCAS		14. MOTHER'S MAIDEN NAME CYNTHIA JOHNS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No NONE		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. LLOYD C. DREW, 607 60TH AVENUE, MD.		Address FAIRMONT HGTS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY 330X IMMEDIATE CAUSE (a) Ruptured Berry aneurysm Rt side DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Beat pulmonary congestion		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from FEB. 23, 1967, to FEB. 23, 1967, that (it) (we) last saw the deceased alive on Feb. 23, 1967, and that death occurred at 11:20, from causes and on the date stated above.			
22a. SIGNATURE Norman K Bohrer		22b. DATE SIGNED AM M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> Feb 24, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Norman K. Bohrer		22d. ADDRESS 3231 Superior Lane, Bowie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-27-67	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR JOHN T. RHINES COMPANY		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 3015 12TH ST. N.E. WASHINGTON, D.C.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/64

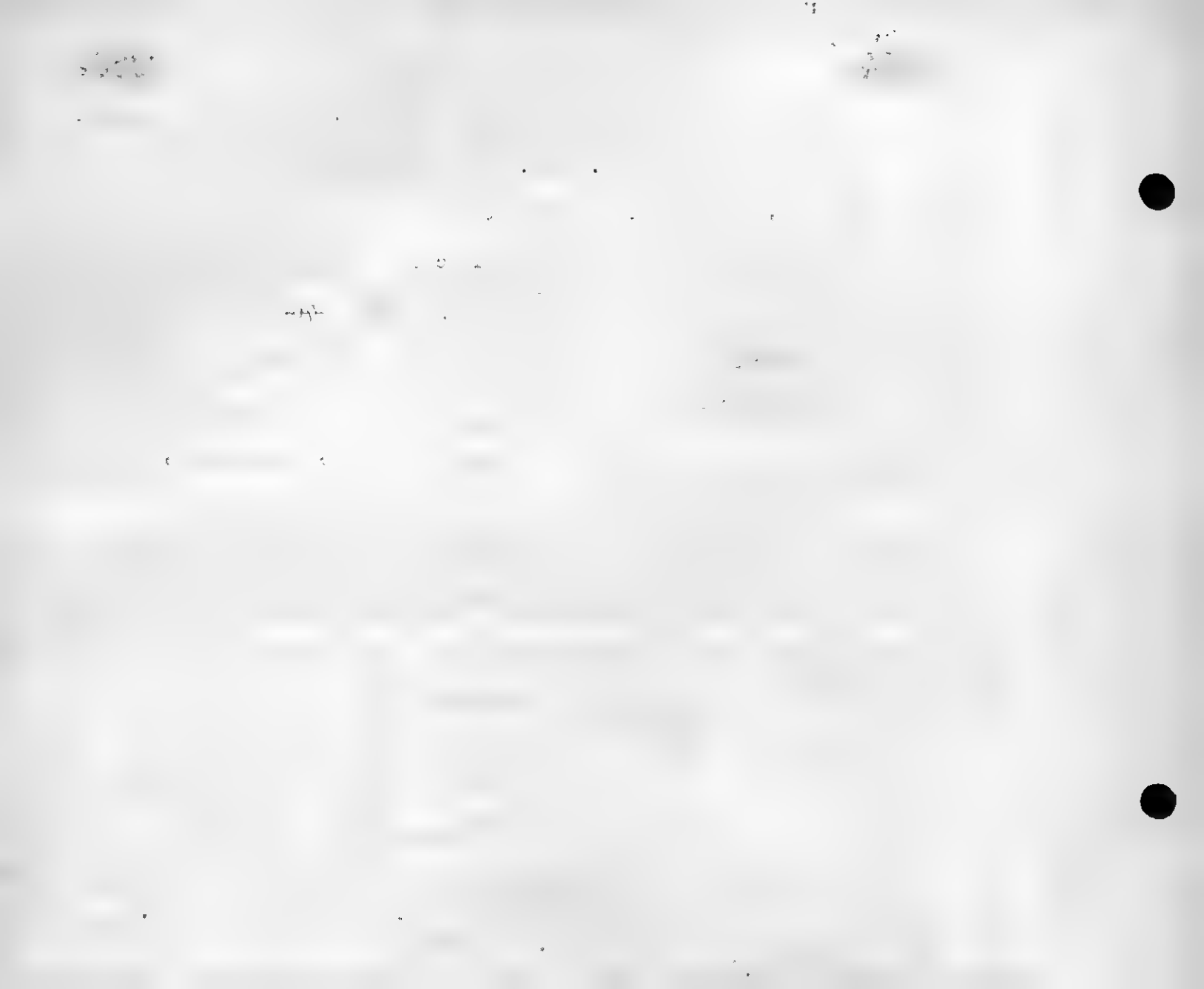
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02544

CERTIFICATE OF DEATH

02537

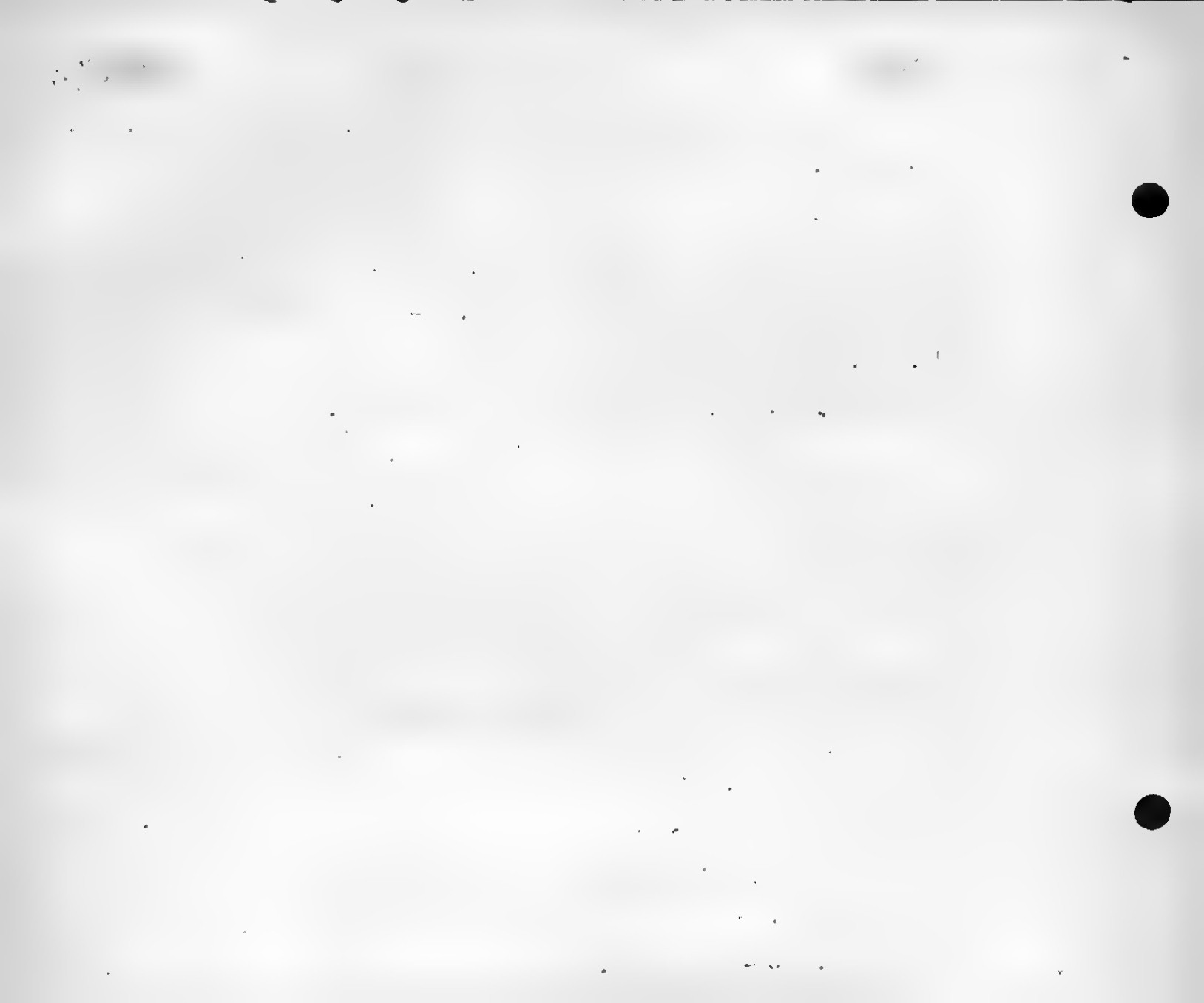
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville	
c. LENGTH OF STAY IN 1b 12 yr. 9 mo.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Road		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cecelia Middle V. Last Driscoll		4. DATE OF DEATH Month February Day 6 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1897
9. AGE (in years last birthday) 70-69 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerical		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Frank Driscoll		14. MOTHER'S MAIDEN NAME Anna Fogarty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 56 , to February 6 , 19 67 , that (I) (we) last saw the deceased alive on February 5 , 19 67 , and that death occurred at 2:20 M, from causes and on the date stated above.			
22a. SIGNATURE James F. Collins		22b. DATE SIGNED 2-6-67	
22c. PHYSICIAN'S NAME (Type) 332 A ONE		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/8/67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE FEB 10 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE John J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02545					02538				
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine				
c. LENGTH OF STAY IN 15					d. STREET ADDRESS Route 4 Box 2-K				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 4--Box 2-K					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Richard Jackson Earnshaw					4. DATE OF DEATH Feb 28 1967				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Aug. 20-1906				
9. AGE (in years last birthday) 60 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Lt. Prince George County Police					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Pinkney A. Earnshaw Sr					14. MOTHER'S MAIDEN NAME Bertha M. Rees				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) no					16. SOCIAL SECURITY NO.				
17. INFORMANT Wife					Address Virginia F. Earnshaw Same as Item #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO <u>Ca 1 Lung and myeloma leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca 1 Lung and myeloma leukemia</u> (c) <u>Stroke</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. INTERVAL BETWEEN ONSET AND DEATH 7 yr									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>12-20</u> , 19 <u>54</u> , to <u>2-27</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>67</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard H. Dobson</u>									
22b. DATE SIGNED Feb. 28-1967									
22c. PHYSICIAN'S NAME (Type) Richard H. Dobson									
22d. ADDRESS Brandywine, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF Mar. 3-67									
23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens									
23d. LOCATION (City, town or county) (State) Waldorf, Maryland									
24. FUNERAL DIRECTOR <u>Simmons Bros</u>									
25a. REC'D BY REGISTRAR Charles Judge									
25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The attending physician remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02546

CERTIFICATE OF DEATH

02539

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) First Middle Last Claude S. Eaton		4. DATE OF DEATH Month Day Year February 6, 1967	
5 SEX male	6 COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/3/1892
9. AGE (In years lost birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Russell Eaton		14. MOTHER'S MAIDEN NAME Fannie Boyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-14-9191	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder with metastases 11 mos. 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, moderately advanced; right tuberculous pleurisy with effusion; generalized arteriosclerosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 1/18/1967 to 2/6/1967, that (we) lost the deceased alive on 2/6/1967, and that death occurred at 1:30 PM from causes and on the date stated above			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/6/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-11-67	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City or town) (County) (State) Arlington D.C.	
24. FUNERAL DIRECTOR P.N. Horton Co		25a. REC'D BY REGISTRAR DATE FEB 10 1967	
25b. REGISTRAR'S SIGNATURE Moe Weiss			



02547

CERTIFICATE OF DEATH

02540

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Ieland Memorial Hospital		d. STREET ADDRESS 915 Carroll Avenue	
3 NAME OF DECEASED (Type or print) First Florence Middle None Last Eisman		4. DATE OF DEATH Month 2 Day 25 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-76
9. AGE (In years last birthday) yrs 90		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Davis		14. MOTHER'S MAIDEN NAME Amanda Wills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Eugene Ieland Memorial		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO (b) <i>Left Pneumonia</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 25, 1967 that (I) (we) last saw the deceased alive on July 25, 1967, and that death occurred at 2:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. King</i>		22b. DATE SIGNED JUL 25, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-28-67	23c. NAME OF CEMETERY OR CREMATORY Ft. Kennerly Cem	23d. LOCATION (City or Town) (County) (State) Colmar Manor Md
24. FUNERAL DIRECTOR <i>W. H. Smith</i>		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
2

74

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

02548

02541

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 10 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Hghts.	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 609 - 48th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Albert H. Erskine		4. DATE OF DEATH Month Day Year Feb. 15, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/83
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Officer		10b. KIND OF BUSINESS OR INDUSTRY Police	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Erskine		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Viola S. Erskine, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) acute Myocardial Infarction 42.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (R) Coronary occlusion DUE TO (c) Post (R) Pneumectomy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-14-1967 , to 2-15-1967 , that (I) (we) last saw the deceased alive on 2-14-1967 , and that death occurred at 2:15 M, from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave. Capitol Hghts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/18/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Wilhelm Funeral Home, 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE FEB 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02549

CERTIFICATE OF DEATH

02542

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hunttsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hunttsville Nursing Home</u>		d. STREET ADDRESS <u>10130 Greenock Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Latimer</u> Middle <u>Evans</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1881</u>
9. AGE (In years lost birthday) <u>85</u> yes		10. IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Staff Accountant C & P Telephone</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Evans</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pratt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>577-01-3032</u>	
17. INFORMANT <u>Elizabeth English</u>		Address <u>10103 Greenock Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of urinary bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus and arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1965</u> to <u>Feb 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> <u>1967</u> , and that death occurred at <u>10:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. B. Washington</u>		22b. DATE SIGNED <u>2/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. B. Washington M.D.</u>		22d. ADDRESS <u>5702 Ridgefield Rd Bethesda 14 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>G. J. ...</u>		DATE <u>FEB 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02550

CERTIFICATE OF DEATH

02543

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 5HR 51MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON d. STREET ADDRESS 7922 SPRINGBROOK LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last MARY ANN FAMOSO				4. DATE OF DEATH Month Day Year FEBRUARY 22 1967			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 FEB 1967	
9 AGE (In years last birthday) yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11 BIRTHPLACE (County & State or foreign country) PRINCE GEORGE'S, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME CHARLES ANTHONY FAMOSO		14 MOTHER'S MAIDEN NAME TERESA AGNES COTTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A	
16. SOCIAL SECURITY NO N/A		17. INFORMANT CHARLES A FAMOSO-FATHER-SAME AS #2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 7593 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE CONGENITAL ABNORMALITIES DUE TO (c) 5HR 51MIN							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 22 FEB 1967 , to 22 FEB 1967 , that (X) (we) lost saw the deceased alive on 22 FEB 1967 , and that death occurred at 11:30 A.M. , from causes and on the date stated above.							
22a. SIGNATURE <i>Michael L. Jordan</i>				22b. DATE SIGNED 22 FEB 67		22c. PHYSICIAN'S NAME (Type) MICHAEL L. JORDAN, CAPT, USAF, MC	
22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331				22e. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. TIME 11:33 A.M.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 27-67		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.		23d LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Simmons Bros. 1661- Good Hope Road SE, Wash, DC				25a REC'D BY REGISTRAR DATE FEB 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

02551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02544

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY N 1b 36 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d STREET ADDRESS 3618 Gleneagles Drive	
3 NAME OF DECEASED (Type or print) Thomas H. Farrington		4 DATE OF DEATH February 19 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-6-88
9 AGE (in years last birthday) 77 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Engineer		10b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11 BIRTHPLACE (State or foreign country) Minnesota		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Frederick Farrington		14 MOTHER'S MAIDEN NAME Charlotte Raynesford	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I		16 SOCIAL SECURITY NO	
17 INFORMANT Marion B. Farrington, Same as #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic and renal failure		INTERVAL BETWEEN ONSET AND DEATH Weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Generalized arteriosclerosis		(b) years	
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of neck of left femur		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home.	
20c TIME OF INJURY Month, Day, Year Hour a.m. Jan. 13 19 67 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) Same as # 2	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-19-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address Riverdale, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2/23/67	23c NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d LOCATION (City or Town) (County) (State) Owego, New York
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

02552

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02545

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Branch		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 10 Morley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Walter Marvese Farrow				4 DATE OF DEATH Month Day Year 2 9 19 67			
5 SEX male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10/5/45	
9 AGE (In years last birthday) 21		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Groom		10b. KIND OF BUSINESS OR INDUSTRY Racing		11 BIRTHPLACE (State or foreign country) Eatons, N. J.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME Theodore Farrow			
14 MOTHER'S MAIDEN NAME Sarah James				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16 SOCIAL SECURITY NO. 637-7750-478				17 INFORMANT Woolley Funeral Home, Longbranch, N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 2-10-67
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				Address (Street, city, town, or county)			
23a. BURIAL CREATION Burial		23b. DATE THEREOF 2/11/67		23c. NAME OF CEMETERY OR CREMATORY White Ridge		23d. LOCATION (City or town) (County) (State) Eatons, N.J.	
24 FUNERAL DIRECTOR Charles R. Law- 802 Madison, Ave.				25a. REC'D BY REG. STAFF DATE FEB 17 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

02553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02546

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND c. LENGTH OF STAY (in days) DOA		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Forrestville	
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			d. STREET ADDRESS 8106 Martha Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lyman Harry Ferrel		First Middle Last		4. DATE OF DEATH Month Day Year February 26 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-21		9. AGE (in years last birthday) yrs 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber Inspector		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank W. Ferrel		14. MOTHER'S MAIDEN NAME Anna B. Crothers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO 579-18-4365		17. INFORMANT Margaret Ferrel, St., N. Forestville,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 5 yrs Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost					19. INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address: Rivendale, Md.		22. DATE SIGNED 2-26-67	
23a. BURIAL (CREMATION REMOVAL) (Specify)		23b. DATE THEREOF March 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Bladensburg, Maryland	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. 517 11th St. S.E. Wash. D.C.		23d. LOCATION (City or town) (County) (State)		23e. REG. NO. REGISTRAR MAR 1 1967	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02554

CERTIFICATE OF DEATH

02547

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4206 74th Ave.	
3 NAME OF DECEASED (Type or print) Cleone Feudale		4. DATE OF DEATH Month Feb. Day 1 Year 1967	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 10, 1913
9 AGE (in years last birthday) 53 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (County & State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Fred Miller		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579 09 5659	
17. INFORMANT George S Feudale		Address Hyattsville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis DUE TO (b) Congestive Heart failure DUE TO (c) Pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 14 hrs 48 hrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/5/67 , 1967, to 2/1/67 , 1967, that (I) (we) last saw the deceased alive on Feb. 1, 1967 , and that death occurred at 1:56 M. from causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. DATE SIGNED ATTENDING PHYS <input checked="" type="checkbox"/> MED PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Frederick E. Musser, M.D.		22d. ADDRESS 4410 74th Ave. Bellemead, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE FEB 7 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

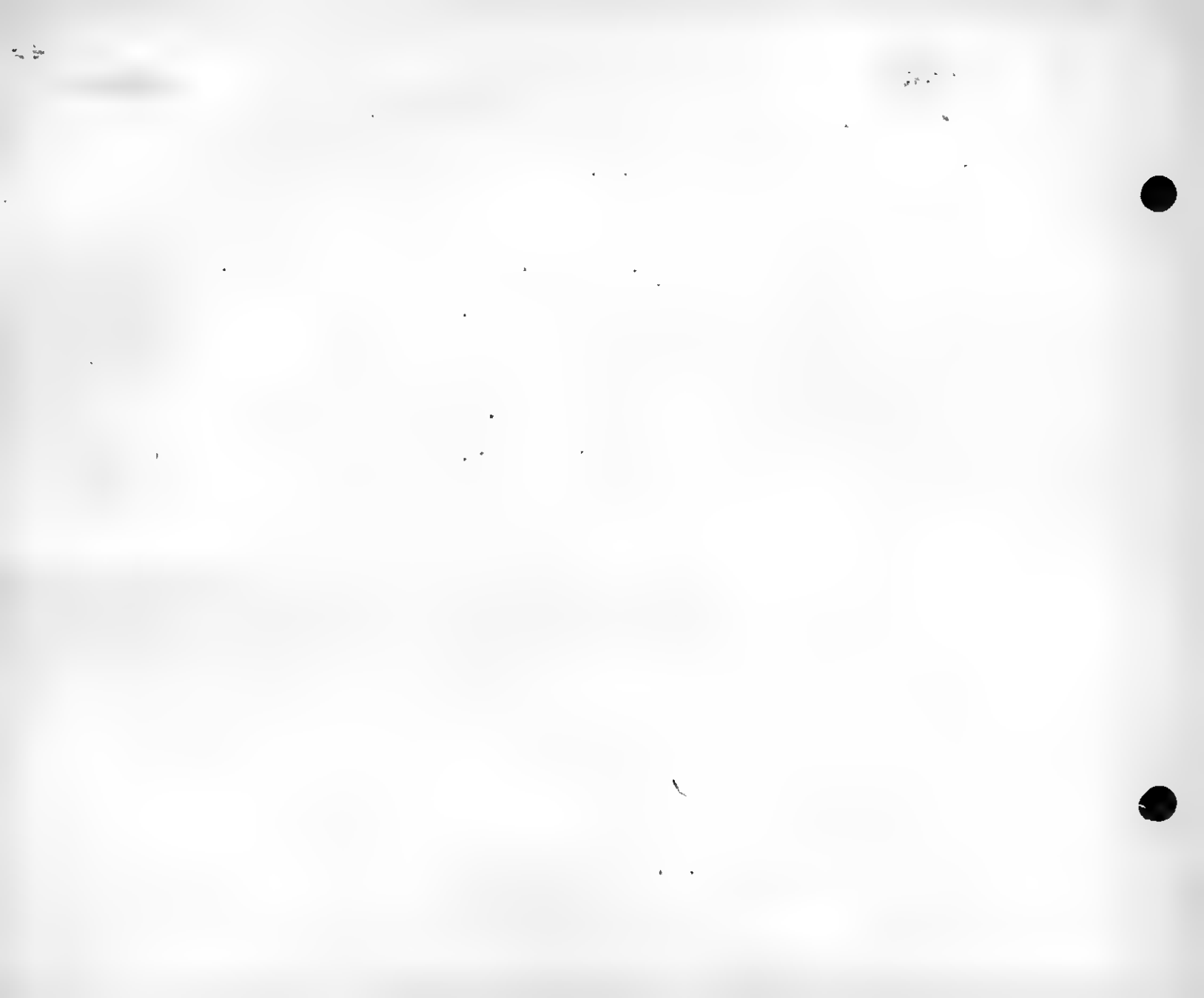
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02548

1 PLACE OF DEATH a COUNTY Prince George b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b D. O. A.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George General Hospital		d STREET ADDRESS 5404 MacBeth Street		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) VICTOR W. FITZWATER		4 DATE OF DEATH Feb. 8, 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 15, 1897	9 AGE (In years, month, days) 69 yrs	10 IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (State or foreign country) West Virginia	
12 CITIZENSHIP OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Samuel Fitzwater		14 MOTHER'S MAIDEN NAME S. Catherine Halterman	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16 SOCIAL SECURITY NO 215 07 5050		17 INFORMANT Address Ina M. Fitzwater Same as #2 (wife)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC TAMPONADE DUE TO Rupture of descending aortic aneurysm into pericardial sac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. same					INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2/8/67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Feb 11, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR FEB 14 1967		25b REGISTRAR'S SIGNATURE Jude	



CERTIFICATE OF DEATH

Reg. Dist. No. 02549

02556

1. PLACE OF DEATH a. COUNTY Prince Geo.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo. Gen. Hosp.				d. STREET ADDRESS 2919 - Country Club Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Emery Fones				4. DATE OF DEATH Month Day Year Feb. 9 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1907		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plumber		10b. KIND OF BUSINESS OR INDUSTRY D.C. Govt.		11. BIRTHPLACE (State or foreign country) Wash., D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Fones				14. MOTHER'S MAIDEN NAME Vivian Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WWII 577-62-1539		17. INFORMANT Mrs. Dora G. Fones (above address)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC HT DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes Vskn							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1-9, 1967, to Jan 1-8, 1967, that I last saw the deceased alive on Jan 1-9, 1967, and that death occurred at 4:00 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE John P. Fones M.D.				ADDRESS (Street, city or town, state) 6300 Reservoir Rd		DATE SIGNED 2-12-67	
PHYSICIAN'S NAME (Type) Nalley's Funeral Home							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/13/67		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS Mt. Rainier, Maryland		24a. REC'D BY REGISTRAR DATE Feb 1 1967	
				24b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

02557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02550

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 5005 Valley Drive	
3 NAME OF DECEASED (Type or print) William Joseph Foy		4 DATE OF DEATH Month 2 Day 13 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 34 yrs
9a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Welder		9b DATE OF BIRTH 2-13-1933	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Steamfitter		11 BIRTHPLACE (State or foreign country) Washington, D. C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Harold B. Foy	
14 MOTHER'S MAIDEN NAME Alice Bowman		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes Korea	
16 SOCIAL SECURITY NO 214-28-2584		17 INFORMANT Mrs. Elizabeth J. Foy Address Same as #2 above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9731 IMMEDIATE CAUSE (a) Combined intoxication DUE TO (b) Alcohol and carbon monoxide DUE TO (c) hrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ran hose from exhaust to inside of car			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drive way of home	
20c TIME OF INJURY Month, Day, Year 11:00pm 2-12-1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) same as #2		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-13-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town or county) Riverdale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATION	23d LOCATION (City or town) (County) (State)
Burial	2/16/1967	Arlington National	Arlington, Virginia.
24 FUNERAL DIRECTOR Arthur Walters		25a RECEIVED BY REGISTRAR FEB 16 1967	
ADDRESS 254 Carroll St., N.W.		25b REGISTRAR'S SIGNATURE Charles Judge	
Washington, D.C.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-27

1-27



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G-36 2/24/67 mh

02558

CERTIFICATE OF DEATH

02551

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE md. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		c. LENGTH OF STAY IN 1b Berwyn Heights, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5615 Seminole St.		d. STREET ADDRESS 5615 Seminole St	
3. NAME OF DECEASED (Type or print) First Middle Last Label E. Frost		4. DATE OF DEATH Month Day Year Feb 13, 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 29, 1889
9. AGE (In years last birthday) 178 77yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Clark C Finnell		14. MOTHER'S MAIDEN NAME Ida H Levi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Fred C Frost		Address Berwyn Heights, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma breast DUE TO (c) 30 mos.			INTERVAL BETWEEN ONSET AND DEATH 14 mos.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 5, 1965 , to Feb 13, 1967 , that (I) (we) last saw the deceased alive on Feb 11, 1967 , and that death occurred at 9:15 PM , from causes and on the date stated above			
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED Feb 13, 1967	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON, MD		22d. ADDRESS 8811 Colesville Rd, Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR FEB 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1007 The Lincoln Cemetery

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

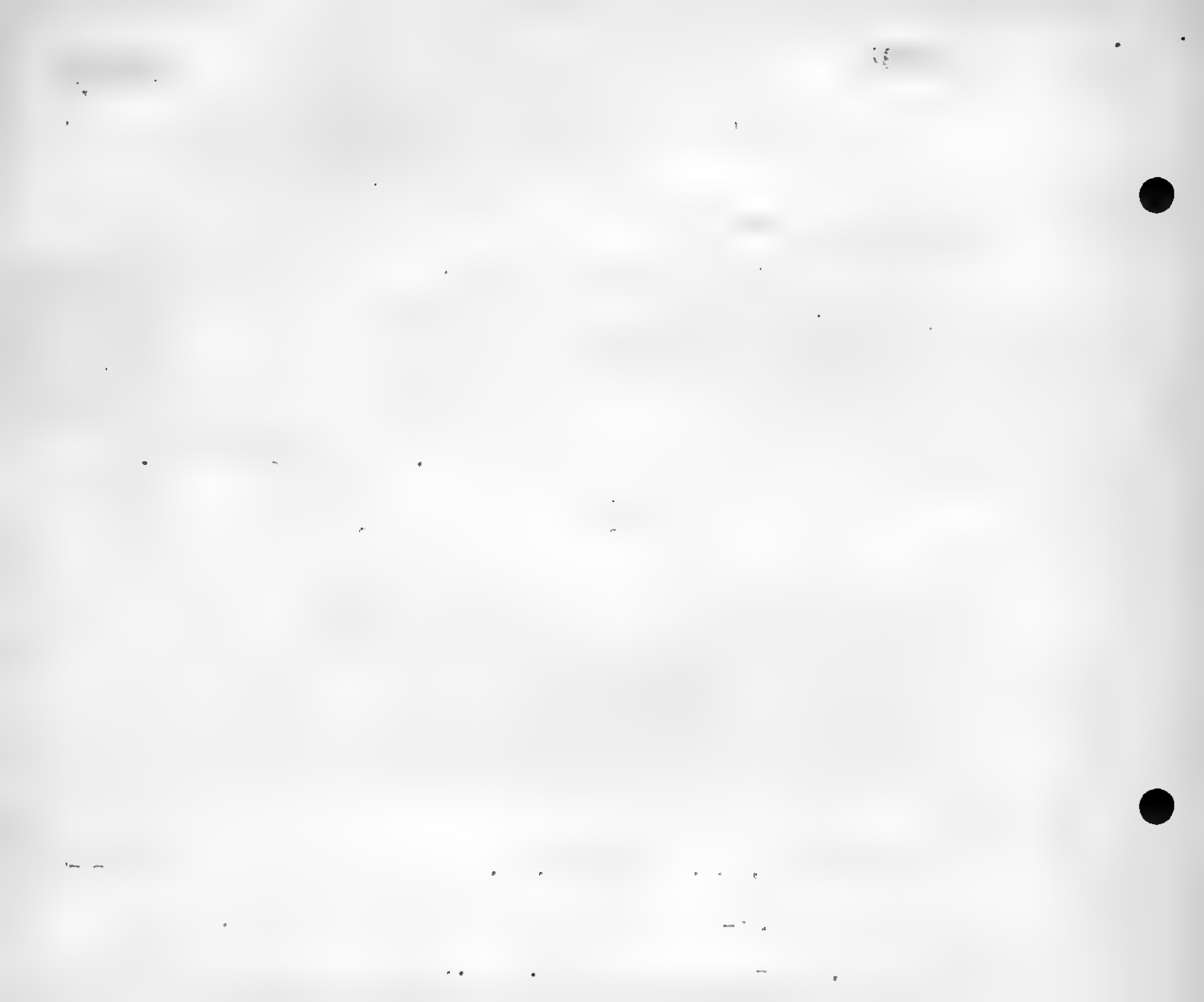
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02552

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Clinton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 7814 Horse Shoe Drive		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Annie Elizabeth Fulmer			4 DATE OF DEATH Month Day Year 2 4 19 67		
5 SEX Female	6 CO. OR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 28 May 1888	9 AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours Min 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Retired		10b. KIND OF BUSINESS OR INDUSTRY Beautician		11 BIRTHPLACE (State or foreign country) Penna	
13 FATHER'S NAME Horace Ehley			12 CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17 INFORMANT Address George G. Hertzog Same as # 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)					INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe			22. DATE SIGNED 2-6-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL (CREMATION, REMOVAL (Specify)) Cremation	23b. DATE THEREOF Feb. 6-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or town)	(County)	(State)
24 FUNERAL DIRECTOR Simmons Bros.			25a. REC'D BY REGISTRAR FEB 7 1967		
25b. REGISTRAR'S SIGNATURE Charles Judge			Address (Street, city, town, or county) Good Hope Road SE. Wash., DC		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in ~~any~~ relevant, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02560

CERTIFICATE OF DEATH

02553

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 5125 C St., S. E.	
3 NAME OF DECEASED (Type or print) First Middle Last Texana T. Glenn		4 DATE OF DEATH Month Day Year February 15, 19 67	
5 SEX female	6 COLOR OR RACE negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/27/1889
9 AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11 BIRTHPLACE (County & State, or foreign country) South Carolina		12 (IT ZEN OF WHAT COUNTRY?) USA	
13 FATHER'S NAME Harve Thompson		14 MOTHER'S MAIDEN NAME Ida Getter	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 578-36-3940	
17 INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of rt. leg, resected by rt. above-knee amputation 2/9/67; thrombosis of basilar artery, old; hypertension; multiple splenic & renal infarctions; chronic myelonephritis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/30/ , 19 67 , to 2/15/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/15/ 1967, and that death occurred at 1:30AM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2-19-67	23c. NAME OF CEMETERY OR CREMATORY Union County	23d. LOCATION (City or Town) (County) (State) Union County S.C.
24. FUNERAL DIRECTOR Rollins 4339- Hunt PL-h.S.		25a. REC'D BY REGISTRAR DATE FEB 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

02561

CERTIFICATE OF DEATH

02554

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 2510 Marlboro Avenue	
3. NAME OF DECEASED (Type or print) First Earl Middle S. Last Graham		4. DATE OF DEATH Month February Day 11, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/05
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Sales Representative		10b. KIND OF BUSINESS OR INDUSTRY Sperry Rand Corp.	
11. BIRTHPLACE (County & State, or foreign country) West Day, New York		12. CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Platt J. Graham		14. MOTHER'S MAIDEN NAME Edna Perqua	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 222-01-9772	
17. INFORMANT Mrs. Rosemary Graham		Address 2510 Marlboro Avenue Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 578X DUE TO PERITONITIS (b) PERFORATION OF BOWEL (c) ANASTOMOSIS OF ILEO SIGMOID			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PORTAL CIRRHOSIS, HEPATIC COMA			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 25, 1966 to FEB 11, 1967 that (I) (we) last saw the deceased alive on FEB 10, 1967, and that death occurred at 10:50 AM, from causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron		22b. DATE SIGNED 2-11-67	
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON		22d. ADDRESS 3503 PERRY ST MT. RAINIER, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR John B. Thomas Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR 8434 Georgia Ave Silver Spring, Md.	
25b. REGISTRAR'S SIGNATURE Charles J. Jago		DATE FEB 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1-67

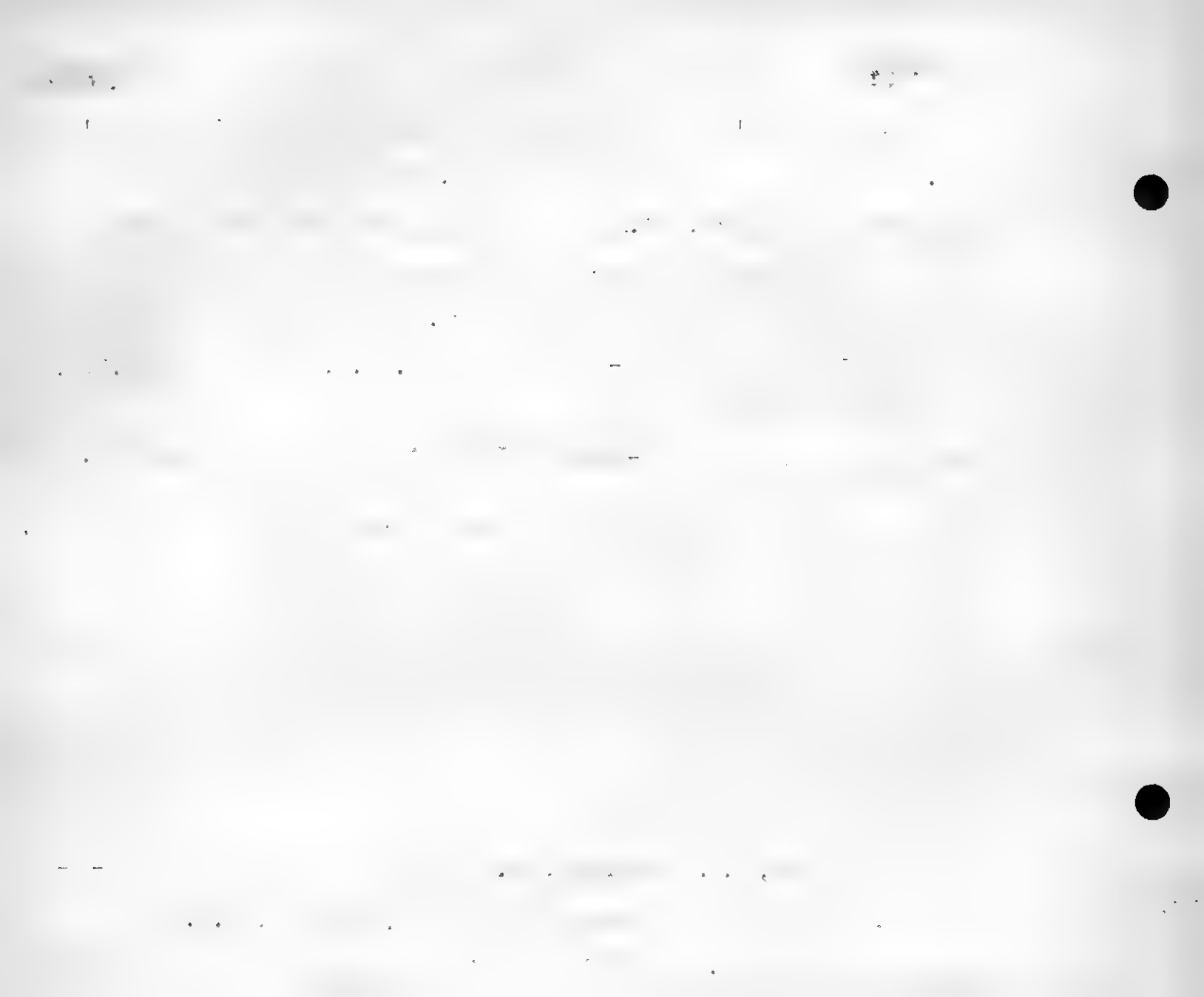
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02562

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02555

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3155 Queens Chapel Road, Apt. 102		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Margaret Mary Greenwell		4 DATE OF DEATH Month 2 Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7 Feb. 1905
9. AGE (In years lost birthday) yrs 62		10. BIRTHPLACE (State or foreign country) Wash., D.C.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James F. Baldwin		14 MOTHER'S MAIDEN NAME Maria Long	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 578-05-3374	
17 INFORMANT James E. Greenwell		Address 1328 So. Buchanan St. Arlington Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 2 mo.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home farm factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 2-16-67	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/67	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Com.		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc. Maryland		25a. REC'D BY REGISTRAR Feb 20 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



FOR STATE
HEALTH DEPT.

02563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02556

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY N. 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS RFD Box 510A Parkers Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Levy		First Middle Last Grimsley		4. DATE OF DEATH 2 17 9 67		Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-95	9. AGE (In years last birthday) yrs 72	10. UNDER 17 Months Days Hours Min	FUND 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Grimsley				14. MOTHER'S MAIDEN NAME Liddia Beavers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218-18-0617		17. INFORMANT Mr. Walter F. Grimsley (Son) Lane, Camp Springs, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 2-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 20-67		23c. NAME OF CEMETERY OR (CREMATORY) Fort Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR Simmons Brothers 1661-Gd. Hope Road SE. Wash.		ADDRESS DC.		25a. REC'D BY REGISTRAR FEB 21 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



02564

CERTIFICATE OF DEATH

02557

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1217 - 51st Ave. N.E.	
3. NAME OF DECEASED (Type or print) James		First Middle Last -- Groomes		4. DATE OF DEATH Month Day Year Feb. 28, 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1893		9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (County & State, or foreign country) S. CAROLINA	
13. FATHER'S NAME UNKNOWN			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UNKNOWN			16. SOCIAL SECURITY NO 215-56-9417		17. INFORMANT LULA SLAUGHTER Address 1217-51ST AVE.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrolyte Imbalance 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Cerebrovascular Accident DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1967 , to Feb. 28, 1967 , that (I) (we) last saw the deceased alive on Feb. 28, 1967 , and that death occurred at 11:45 PM from causes and on the date stated above					
22a. SIGNATURE Norman K. Bohrer		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. PM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March, 1967	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M.D.		22d. ADDRESS Prince George's General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Park		23d. LOCATION (City or Town) (County) (State) Landover Md	
24. FUNERAL DIRECTOR Rollins Home Inc 4339 Hunt Rd		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 6 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit permit. This permit should be filed with the State Dept. of Health prior to burial, cremation or other disposition of the body.

VR A15 (4)
20 M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02565		02558									
1. PLACE OF DEATH a. COUNTY Pr. George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. George's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b One hour		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lanham					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS 5601 Barker Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Phillip Last GUINIVAN			4. DATE OF DEATH Month February Day 21 Year 19 67								
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 Jan. 1897		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machinist				10b. KIND OF BUSINESS OR INDUSTRY P. A. Railroad		11. BIRTHPLACE (County & State, or foreign country) Cambria Co Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Guinivan						14. MOTHER'S MAIDEN NAME Mary Vogel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 716 12 9171		17. INFORMANT Address Mrs. Marie K. Guinivan Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure & pulmonary edema 7071 DUE TO Atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH One hour 3 years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 18 May , 19 64 , to 21 Feb , 19 67 , that (I) (we) last saw the deceased alive on 21 Feb. 19 67 , and that death occurred at 5 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C. J. Houmann						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 21 Feb., 1967	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann						22d. ADDRESS Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/67		23c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier				23d. LOCATION (City, town or county) (State) Cresson Pa.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR FEB 23 1967		25b. REGISTRAR'S SIGNATURE <i>William J. ...</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>02566</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02559</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY Pr. George's MARYLAND</p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Pr. George's</p>					
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p>Riverdale</p>				<p>c. LENGTH OF STAY IN 1b</p> <p>3 hours</p>		<p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p>Hyattsville</p>				<p>d. STREET ADDRESS</p> <p>4217 Jefferson St.</p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p>Leland Memorial Hospital</p>						<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Ramez Middle Selim Last HADDAD</p>						<p>4. DATE OF DEATH</p> <p>Month Feb. Day 23 Year 1967</p>					
<p>5. SEX</p> <p>Male</p>		<p>6. COLOR OR RACE</p> <p>W</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p>4 July, 1900</p>		<p>9. AGE (In years last birthday)</p> <p>66 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Wholesale Grocer</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>Own business</p>		<p>11. BIRTHPLACE (County & State, or foreign country)</p> <p>Syria</p>			<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		
<p>13. FATHER'S NAME</p> <p>Selim Haddad</p>						<p>14. MOTHER'S MAIDEN NAME</p> <p>Zaheeda Nasseem</p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> <p>no</p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Address</p> <p>Daughter, Miss Alice Haddad, above</p>					
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Congestive Heart Failure</p> <p>1500 DUE TO Gen. Arteriosclerosis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown</p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity (estimated weight: 400 lbs.)</p>										<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>3 hours</p>	
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. 19 p.m.</p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from 23 Feb., 1967, to 23 Feb., 1967, that (I) (we) last saw the deceased alive on 23 Feb., 1967, and that death occurred at 8 PM, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE C. J. Houmann Dr. Kehoe notified. Body released</p>						<p>22b. DATE SIGNED 23 Feb. 1967</p>					
<p>22c. PHYSICIAN'S NAME (Type) C. J. Houmann</p>						<p>22d. ADDRESS Riverdale, Md. 20840</p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p>Burial</p>			<p>23b. DATE THEREOF</p> <p>2/27/67</p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p>Ft. Lincoln Cemetery</p>			<p>23d. LOCATION (City, town or county) (State)</p> <p>Prince Georges Co. Md.</p>			
<p>24. FUNERAL DIRECTOR</p> <p>W. S. A. Miller Co. 2201 14th St. N.W.</p>						<p>25a. REC'D BY REGISTRAR</p> <p>FEB 27 1967</p>		<p>25b. REGISTRAR'S SIGNATURE</p> <p><i>William J. Jones</i></p>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02567

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02561

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c LENGTH OF STAY IN b 1 week d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6315 61st. Place		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Virginia b COUNTY Blackstone c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 303 Courthouse Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Josephine Haney		4 DATE OF DEATH Month 2 Day 3 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-24-1902
9 AGE (In years lost birthday) 64 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Domestic	
11 BIRTHPLACE (State or foreign country) Anne Arundel Co., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Joseph Edward Marshall		14 MOTHER'S MAIDEN NAME Mary Priscilla Dove	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Mazie Cummings, Wash. D.C.		Address 5429 Marlboro Pike 20028	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 15 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion a death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 2-3-67	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 6, 1967	
23c NAME OF CEMETERY OR CREMATORY St. James Chr. Cemetery		23d LOCATION (City or Town) (County) (State) Lothian A. A. Co., Md.	
24 FUNERAL DIRECTOR ADDRESS Hutchins Funeral Home Owings, Maryland		25a REC'D BY REGISTRAR DATE FEB 8 1967	
25b REGISTRAR'S SIGNATURE Walter Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02568

CERTIFICATE OF DEATH

02562

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Bop 107</u> <u>Harrod Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Syatts</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrod Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Syattsville Nursing Home</u>		d. STREET ADDRESS <u>4500 Ridge Rd Harrod Md</u>	
3. NAME OF DECEASED (Type or print) <u>Daisy Burgess Hardesty</u>		4. DATE OF DEATH <u>2</u> <u>4</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1884</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR <u>4</u> Months <u>4</u> Days <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Harrod Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Susan Harriet Burgess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>413-56-0094-11</u>	
17. INFORMANT <u>LeRoy Hardesty</u>		Address <u>Budaville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Generalized Arteriosclerosis</u> (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>67</u> , to <u>2/4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u>		22b. DATE SIGNED <u>2/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u>		22d. ADDRESS <u>911 S. IVER Spring AVE, SILVER SPRING Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	23d. LOCATION (City or town) (County) (State) <u>Bristol Md</u>
24. FUNERAL DIRECTOR <u>Thomas Hardesty</u>		25a. REC'D BY REGISTRAR <u>12 R. D. Kelly Ave, Annapolis Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 7 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02569

CERTIFICATE OF DEATH

02563

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 9510- 50th Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Frank M. Harrison		4. DATE OF DEATH Month Day Year Feb. 9 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/95
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Houses	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Frank Harrison	
14. MOTHER'S MAIDEN NAME Ella Otis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W W 1	
16. SOCIAL SECURITY NO. 579 03 1574		17. INFORMANT Frank Harrison Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Severe pulm. edema & respiratory distress DUE TO (b) Carcinoma of lung, mostly rt. upper lobe with DUE TO (c) metastasis to adrenal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Infarct rt. parietal lobe of brain recent; nutritional cirrhosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that the (this hospital) attended the deceased from Feb. 2 , 1967, to Feb. 9 , 1967, that we (we) last saw the deceased alive on Feb 9 1967, and that death occurred at 9:45 A.M. , from causes and on the date stated above.	
22a. SIGNATURE M.P. Diaz-Liob, M.D.		22b. DATE SIGNED Feb. 9, 1967	
22c. PHYSICIAN'S NAME (Type) M. P. Diaz-Liob, M.D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City or town) (County) (State) Suitland 'Pro Geo Md.
24. FUNERAL DIRECTOR F, Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 14 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

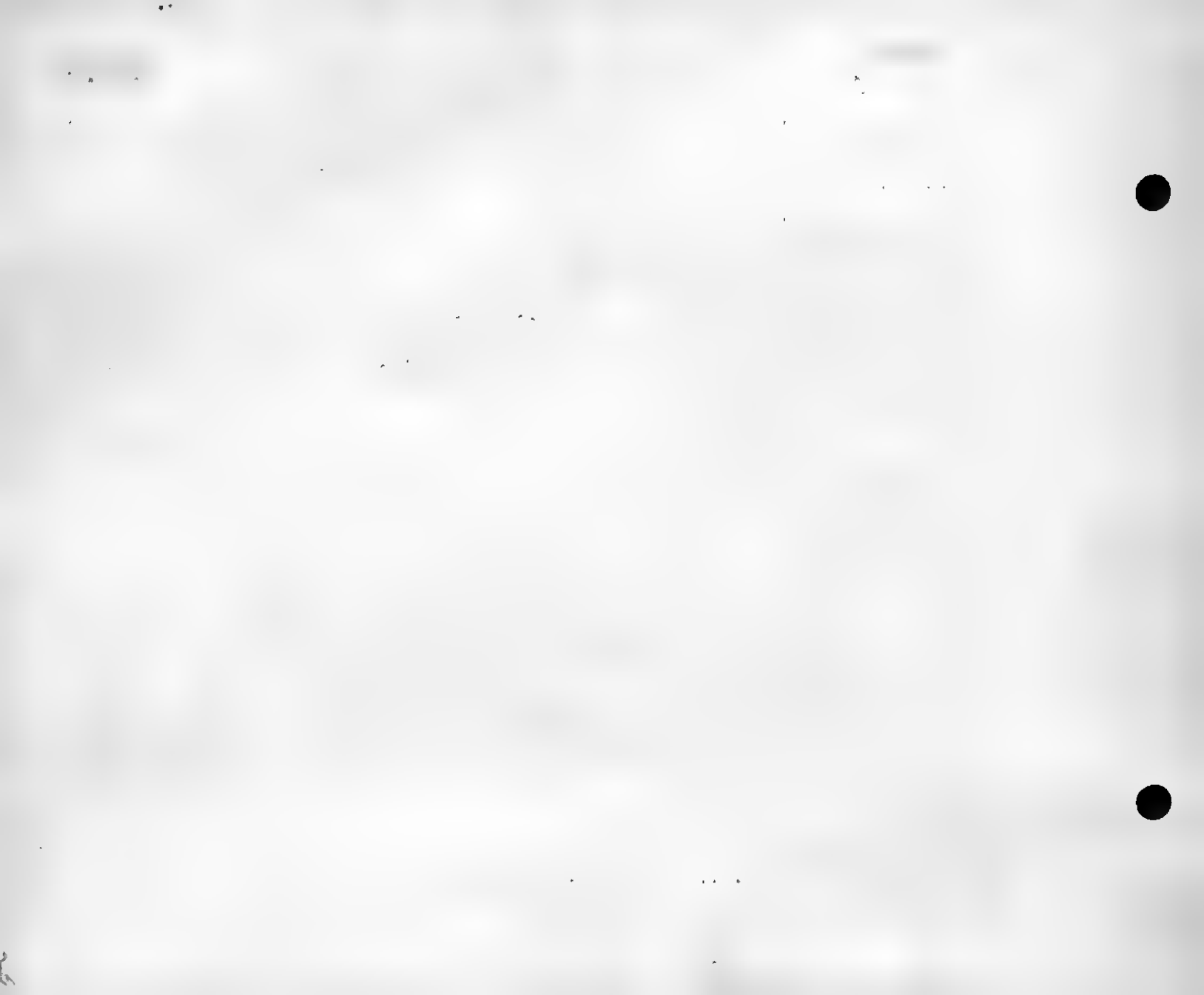
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02564

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mouht Rainier 16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 4115 Rainier Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Fred Henry Haut			4 DATE OF DEATH Month Day Year 2 9 1967		
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 3-1-34	9 AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER		10b. KIND OF BUSINESS OR INDUSTRY YORK REFRIG. CO		11 BIRTHPLACE (State or foreign country) SCRANTON, PENN'A.	
13 FATHER'S NAME HAROLD HAUT			14 MOTHER'S MAIDEN NAME BELLE YOUNG		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 577-44-4839		17 INFORMANT MRS BELLE Y. HAUT. Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Heart Failure DUE TO (c) Generalized myocardial hypertrophy					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.			22. DATE SIGNED 2-10-67		
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland			Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 13 FEB 1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN	
24. FUNERAL DIRECTOR W. W. CHAMBERS, Co. RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE FEB 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	
23d. LOCATION (City or town) (County) (State) BLADENSBURG, MARYLAND					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

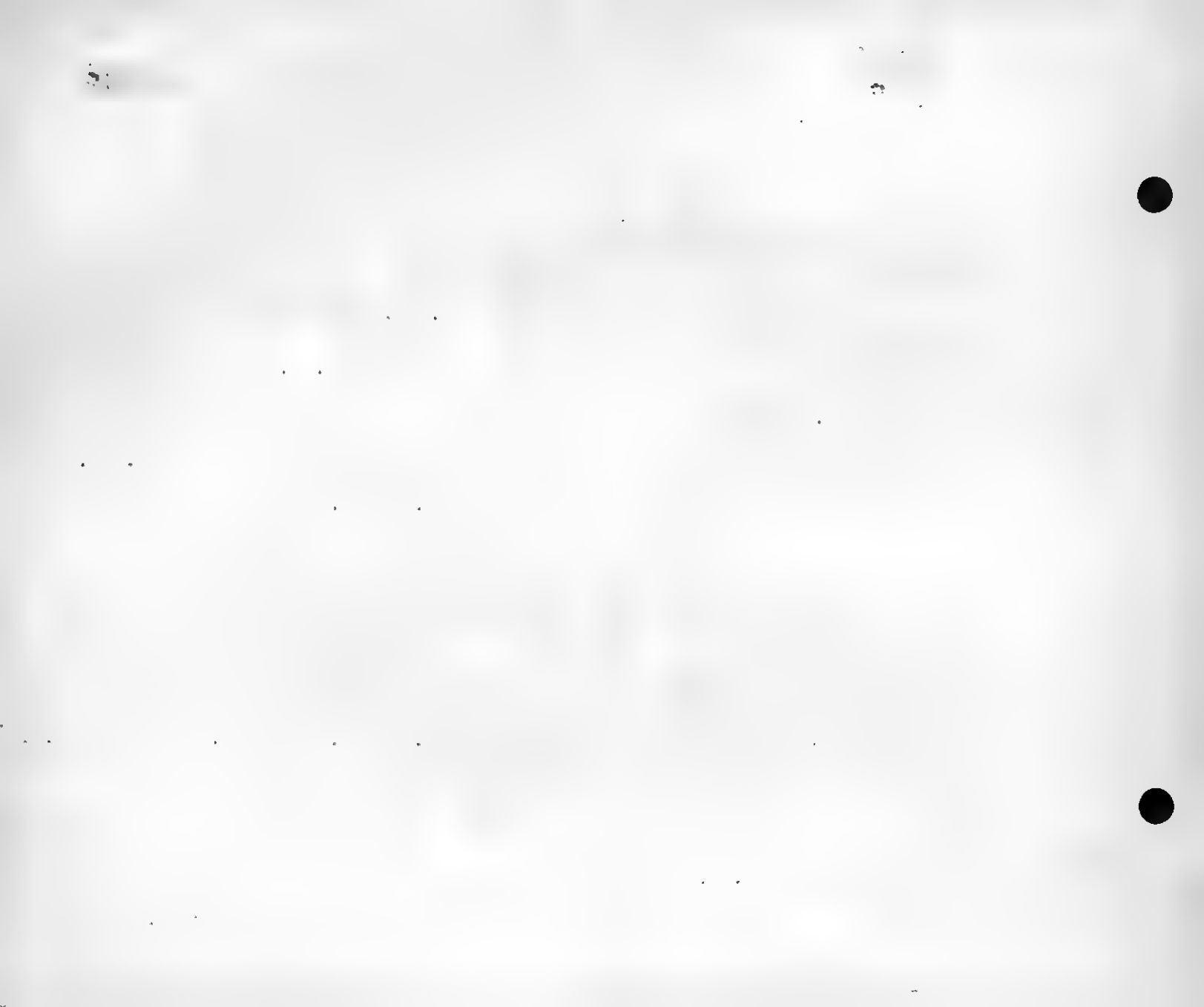
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02571

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02565

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 4636 Davis Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last Alan Bernard Hawkes			4 DATE OF DEATH Month Day Year 2 8 1967			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Nov. 28, 1947 19 yrs		9 AGE (In years last birthday) 19 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (State or foreign country) Washington D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward P. Hawkes						14. MOTHER'S MAIDEN NAME Mary A. Fitzpatrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary Pack #43 Springler Way Balt. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of brain (.22 cal.) 9198 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)								INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) accidental discharge of revolver					
20c. TIME OF INJURY Month, Day, Year 8:00pm p.m. 2-8 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) parking lot, 300blk., Swan Rd., Suitland, P.G., Md.		20f. (City or town) (County) (State) Suitland, Prince Georges, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								22. DATE SIGNED 2-10-67	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 2/13/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE FEB 15 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Filed Page 3 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02572

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02566

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if instit on Res dence before admision) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY M			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		15-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4409 Fernhill Road		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Oscar James Hawley				4 DATE OF DEATH Month Day Year 2 13 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1904		9. AGE (In years last birthday) yrs 62	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor contractor		11b. KIND OF BUSINESS OR INDUSTRY Buildings		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William M Hawley				14. MOTHER'S MAIDEN NAME Nary E Salmon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Address Joe Hawley Cameron North Carolina			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)							INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 2-14-67			
23a. BURIAL, CREMATION, REMOVAL, SPECIES Burial		23b. DATE THEREOF Feb 15, 1967		23c. NAME OF CEMETERY OR CHURCH Hillmon Grove Church		23d. LOCATION (City or town) (County) (State) Harnett County N. Carolina	
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR FEB 16 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE
HEALTH DEPT.

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02573

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02567

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		c LENGTH OF STAY IN 1b Hillside	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1206 56th. Avenue		d STREET ADDRESS 1206 56th. Avenue	
3 NAME OF DECEASED (Type or print) Robert Lee Heffron		4 DATE OF DEATH Month 2 Day 28 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4 Sept. 1897
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10b KIND OF BUSINESS OR INDUSTRY Gas Company	9 AGE (in years last birthday) 69 yrs
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Andrew Jackson Heffron		14 MOTHER'S MAIDEN NAME Mary K. Beach	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO.	
17. INFORMANT Agnes L. Heffron,		Address Same As # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 974X IMMEDIATE CAUSE (a) Asphyxiation DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hanged self in bathroom of home			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Bathroom of home same as #2	
20c TIME OF INJURY Month, Day, Year Hour a.m. 1:35pm p.m. 2-28- 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Bathroom of home		20f (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a B.R.A. OR MATION REMOVAL (Specify) Burial	23b DATE THEREOF March 4, 1967	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d LOCATION (city or town) (County) (State) Prince Georges, Maryland
24 FUNERAL DIRECTOR Robert E. Wilhelm		25a REC'D BY REGISTRAR Charles Judge	
Funeral Home 4308 Suitland Rd. Suitland, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02574

CERTIFICATE OF DEATH

02568

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>DISTRICT HEIGHTS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RECENT NURSING HOME</u>		d. STREET ADDRESS <u>7816 DIST. HGTS. PARKWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MAE</u> Last <u>HENDERSON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/22</u>
9. AGE (In years lost birthday) <u>45</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ACIE GEARHEART</u>		14. MOTHER'S MAIDEN NAME <u>ETHEL MC LAUGHLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>DOUGLAS HENDERSON</u>		Address <u>SAME AS # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>171X</u> DUE TO (b) <u>Carcinoma of Cervix - metastasis</u> DUE TO (c) <u>Right Ureteral obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 yrs.</u> <u>6 mos.</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>2-27, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-27, 1967</u> , and that death occurred at <u>2:30</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>W.B. Sheer</u>		22b. DATE SIGNED <u>2-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>		22d. ADDRESS <u>6400 MARLBORO PIKE S.E. WASH. D.C. 20028</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MARCH 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BLUEWELL, WEST VIRGINIA</u>
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02575

CERTIFICATE OF DEATH

02569

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4503 34th Street	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Louise Hennigan		4 DATE OF DEATH Month Day Year February 9 1967	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-28
9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Maholchic		14. MOTHER'S MAIDEN NAME Claire Wasley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 330A ACUTE CEREBROVASCULAR ACCIDENT DUE TO RUPTURED ANEURYSM Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 29 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-7 , 19 67 , to 2-9 , 19 67 , that (I) (we) last saw the deceased alive on 2-8 19 67 , and that death occurred at 3:12 A.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 2-9-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/13/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REC'D BY REGISTRAR DATE FEB 15 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02576

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02570

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood	
c. LENGTH OF STAY IN 1b 1 mo.-16 days		d. STREET ADDRESS 4315 - 40th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Geo. Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle E. Last Herbert		4. DATE OF DEATH Month Feb. Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Buyer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry S. Miller		14. MOTHER'S MAIDEN NAME Frances Owings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-9873	
17. INFORMANT Mr. Joseph W. Herbert (above address)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Coronary sclerosis DUE TO (c) Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) POST OP INT OBSTRUCTION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1950 to Feb , 19 67 , that (1) (we) last saw the deceased alive on Jan 31 1967 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED Feb 1 1967	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR Maryland Rainier	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 6 1967	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY Prince George's MARYLAND						2 USUAL RESIDENCE (Where deceased lived f institution, Residence before admission) a STATE Maryland b COUNTY Prince George's					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN lb DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital						d STREET ADDRESS 7704 Allentown Road				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Priscilla June Trout First Middle Last						4 DATE OF DEATH February 4 19 67 Month Day Year					
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2/24/31		9 AGE (In years last birthday) 35 yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Maryland / Roanoke Co., Va.				12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME David Malcolm Trout, Sr.						14 MOTHER'S MAIDEN NAME Mary Louise Bradley					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16 SOCIAL SECURITY NO. none		17 INFORMANT Emil R. Husband Address Roanoke, Va. Mary B. Housenfleur 14601 Camp Spring, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pericarditis DUE TO (b) (organism undetermined) DUE TO (c) and Broncho pneumonia, bilateral										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Kehoe, M.D.						22. DATE SIGNED 2-4-67					
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Riverdale, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/7/67		23c NAME OF CEMETERY OR REPOSITORY Fairview				23d LOCATION (City or Town) (County) (State) Roanoke Roanoke Va.			
24 FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS Hyattsville, Md.						25a REC'D BY REGISTRAR DATE FEB 7 1967		25b REGISTRAR'S SIGNATURE Charles Judge			

99

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 02571											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 903 Philip Powers Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Franklin Howell				4. DATE OF DEATH February 13, 1967				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1892		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY tenant farm				11. BIRTHPLACE (State or foreign country) Oella Maryland			
13. FATHER'S NAME William Howell				14. MOTHER'S MAIDEN NAME Louise Huff				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no				16. SOCIAL SECURITY NO. 229 32 8766				17. INFORMANT Paul L. Howell, 312 Wash. Blvd, Jessup, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HT FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HT DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS GYN											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 2-16-67			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-16-67		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cem		22d. LOCATION (City, town, or county) (State) Charlestown W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
He Witt Sanderson				Laurel Md				DATE 2-23-1967		Charles J. J.	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A)5ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2, 17 Film 6356 3/7/67 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02579

02573

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE Virginia Md. b. COUNTY Fairfax FR. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 524 Forest Rd. 609 Park Street	
3 NAME OF DECEASED (Type or print) First Middle Last EARL W. HUNT		4 DATE OF DEATH Month Day Year Feb. 7, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 16, 1919
9 AGE (in years birthday) yrs 47		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George B. Hunt		14. MOTHER'S MAIDEN NAME Lucy Shaw	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO 579 12 5944	
17 INFORMANT Albert B. Hunt		Address 609 Park St. SE (brother) Vienna, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ASHD DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 2/7/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 '67

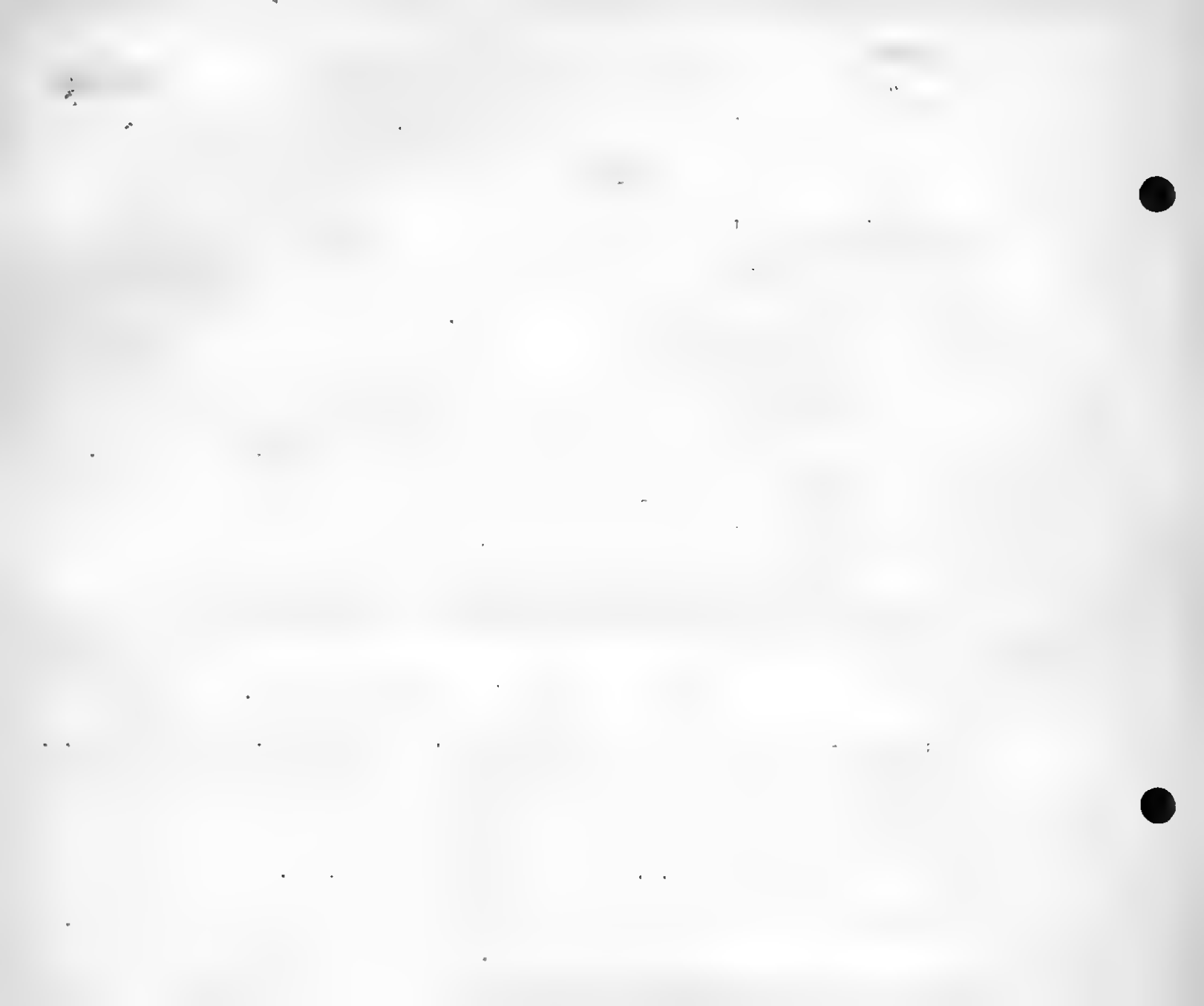
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02580

02574

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 301 50th Avenue	
3 NAME OF DECEASED (Type or print) Raymond Samuel Hunt		4 DATE OF DEATH Month February Day 17 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 21, 1929
9 AGE (In years last birthday) 37 yrs		10 UNDER 1 YEAR Months 1 Days 19 HOURS 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Food Store	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Raymond S Hunt Sr		14. MOTHER'S MAIDEN NAME Annie M Williamson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 578 36 5274	
17 INFORMANT Alleen M Hunt		Address Capitol Heights, Md.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY 5164 Bilateral hemiothorax AND Laceration of brain Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 1 hour			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSES PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision.	
20c. TIME OF INJURY Month Day Year Hour a.m. 5:00pm 2-17-67 19	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 75th Ave. and Forest Rd.	20f. (City or town) (County) (State) Hyattsville P.G. Md
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 2-18-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md. (County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR FEB 23 1967	
Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02581

CERTIFICATE OF DEATH

02575

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	c. LENGTH OF STAY IN 1b 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 22 Farms Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Joseph H. Ireland		4 DATE OF DEATH Month Day Year February 11, 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/11/84
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired repairman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11 BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Ireland	
14. MOTHER'S MAIDEN NAME Martha Ann Phipps		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Nettie H. Ireland Address Laurel, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Interval between ONSET AND DEATH Massive pulmonary embolism w/ suppurative Subsiding acute cholecystitis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1967, to Feb. 11, 1967, that (I) (we) lost saw the deceased alive on Feb. 11, 1967, and that death occurred at 8:20 AM, from causes and on the date stated above.			
22a. SIGNATURE Wm. A. Holbrook M.D.		22b. DATE SIGNED 2/11/67	
22c. PHYSICIAN'S NAME (Type) Wm. A. Holbrook, M.D.		22d. ADDRESS 4500 College Ave., College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

02582

CERTIFICATE OF DEATH

02576

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 9 days		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4707 41st Place	
3 NAME OF DECEASED (Type or print) First Middle Last Baby Boy Jackson		4 DATE OF DEATH Month Day Year Feb. 21 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 Feb. 1967
9 AGE (In years last birthday) 9		IF UNDER 1 YEAR Months Days Hours Min. 9	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Michael Arthur Brown		14. MOTHER'S MAIDEN NAME Mildred Veronica Jackson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT Ethel Jackson-4704 41st Pl		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7630 Pneumonitis IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from Feb. 12, 1967 , to Feb. 21, 1967 , that he (we) last saw the deceased alive on Feb. 22, 1967 , and that death occurred at 6:00 PM from causes and on the date stated above.			
22a SIGNATURE Edmond Rodriguez		22b. DATE SIGNED Feb. 23, 1967	
22c. PHYSICIAN'S NAME (Type) Edmond Rodriguez, M.D.		22d. ADDRESS Prince George's General Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2/27/67	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d LOCATION (City or Town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR Stewart		25a. REC'D BY REGISTRAR DATE FEB 27 1967	
25b REGISTRAR'S SIGNATURE Harley Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02583

CERTIFICATE OF DEATH

02577

1 PLACE OF DEATH a. COUNTY Pro Georges County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b College Heights University Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pro Geo General Hospital		d. STREET ADDRESS 4207 College Heights Drive	
3 NAME OF DECEASED (Type or print) Altha Jane Jardine		4. DATE OF DEATH Month Feb Day 12 Year 19 67	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov 9, 1886
9. AGE (In years last birthday) yrs 80		IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (County & State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel C Mollohan		14. MOTHER'S MAIDEN NAME Virginia Mc Cray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 10 8626	
17. INFORMANT Miron Eugene Jardine		Address College Heights, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 490X Pneumonia, bilateral IMMEDIATE CAUSE (a) Pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1963 , to 2-12, 1967 that (I) (we) last saw the deceased alive on 2-12 19 67 , and that death occurred at 2-12 M, from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR FEB 16 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02584

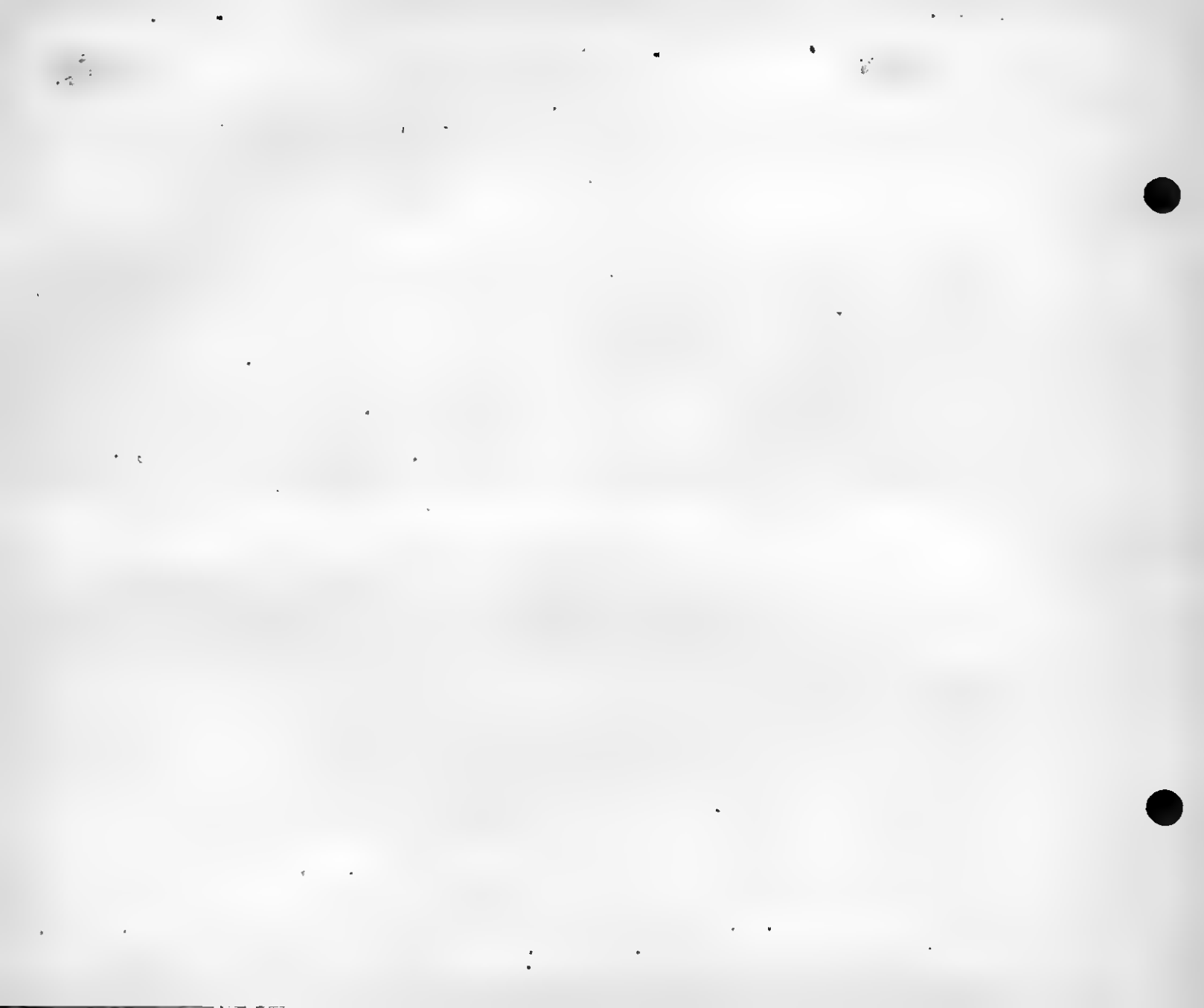
CERTIFICATE OF DEATH

02578

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 hrs. 45 mins	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital					d. STREET ADDRESS 1139 Plum Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Baby		First Boy		Middle Jarrell		Last Jarrell		4. DATE OF DEATH Month Feb. Day 28 Year 19 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1967		9. AGE (In years last birthday) Yrs 24 Mths 6 Days 45 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Md.			12. CIT ZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arthur Joseph Jarrell				14. MOTHER'S MAIDEN NAME Elaine K. Dolby				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur J. Jarrell		Address Same as 2 D, D.		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb. 27, 19 67 , to Feb. 28, 1967 , that (I) (we) last saw the deceased alive on Feb. 28, 1967 , and that death occurred at 1:25 PM , from causes and on the date stated above.								
22a. SIGNATURE John Perkins				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-1-67		
22c. PHYSICIAN'S NAME (Type) John Perkins				22d. ADDRESS Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields		23d. LOCATION (City or Town) (County) (State) Millersville, A.A. Md.		
24. FUNERAL DIRECTOR Charles F. Deibel Jr. Hopping Funeral Home Annapolis, Md.				25a. REGD BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02579

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5311 Crittenden St.	
3 NAME OF DECEASED (Type or print) Evans John Javaras		4 DATE OF DEATH Month 2 Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 25 March 1897
9 AGE (in years last birthday) 69 YES		10 F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired waiter		10b KIND OF BUSINESS OR INDUSTRY Hotel	
11 BIRTHPLACE (State or foreign country) Greece		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOC. A. SECURITY NO. 579 01 6148	
17 INFORMANT Thelma M Javaras		Address Hyattsville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Metastatic carcinoma DUE TO Adeno carcinoma of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	20f (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Feb 23, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or town) _____ (County) _____ (State) _____ Colmar Manor, Pro Geo Md.
24 FUNERAL DIRECTOR P. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a REC'D BY REGISTRAR DATE FEB 24 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02586

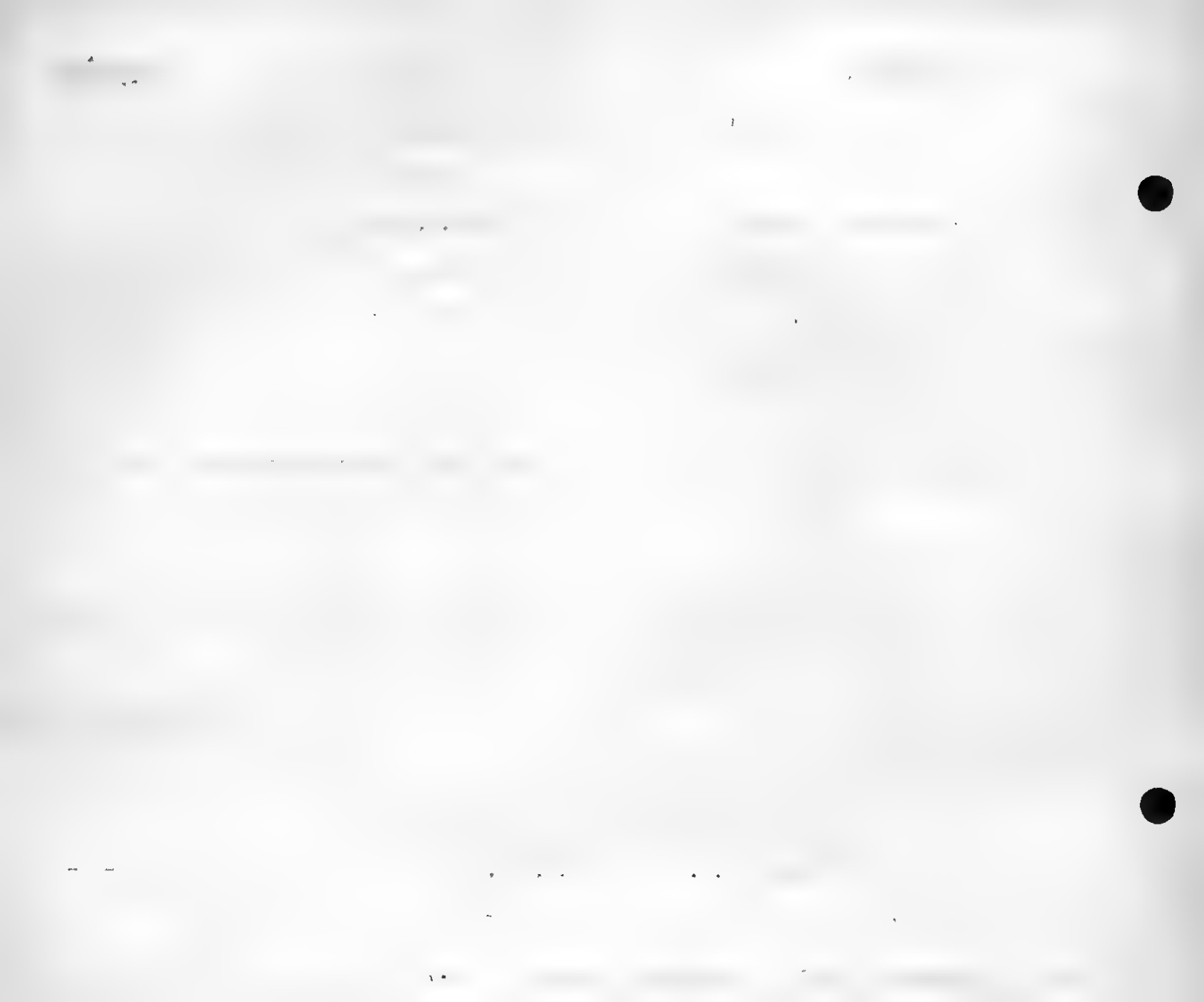
02580

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Ann Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Daniel Fred Johnson		4 DATE OF DEATH Month 2 Day 21 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4 April 1914
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		9b KIND OF BUSINESS OR INDUSTRY	
10a BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME Bessie Macklin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Mrs. Eva Johnson-Route 1 Box 394-B		Address	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 2-22-67	
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL, ETC. Burial		23b DATE THEREOF 2/25/67	
23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Ceme.		23d LOCATION (City or Town) (County) (State) Maryland	
24 FUNERAL HOME Stewart Funeral Home-4001 Benning Rd.		25a REC'D BY REGISTRAR N. FEB 27 1967	
25b REGISTRAR'S SIGNATURE <i>John Kehoe</i>			



CERTIFICATE OF DEATH

02587

02581

1. PLACE OF DEATH a. COUNTY PR. GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE c. LENGTH OF STAY IN b 29 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5422 Quesada St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE d. STREET ADDRESS 5422 QUESADA ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WILBUR JONES		4. DATE OF DEATH Month Day Year FEB 5 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 AUG 1906
9. AGE (in years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days 2 MOS	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKLAYER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE DAVID JONES		14. MOTHER'S MAIDEN NAME CATHERINE LOUISE CUNNINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 217-09-2308	
17. INFORMANT MRS. HAZEL JONES		Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (b) BRONCHOGENIC CARCINOMA (c) 1 YEAR PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 2 MOS 1 YEAR	
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
21. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24. (City or town) (County) (State)
25. I certify that (I) (this hospital) attended the deceased from 12:12 1966 to 5 FEB 1967 , that (I) (we) last saw the deceased alive on 3 FEB 1967 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
26. SIGNATURE C. J. Houmann		27. DATE SIGNED 5 FEB 1967	
28. PHYSICIAN'S NAME (Type) C. J. HOUMANN		29. ADDRESS RIVERDALE MD	
30. BURIAL, CREMATION, REMOVAL (Specify) Burial	31. DATE THEREOF Feb 8, 1967	32. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	33. LOCATION (City, town or county) (State) Colmar Manor Pro Geo Md.
34. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		35. ADDRESS Hyattsville, Md.	
36. REC'D BY REGISTRAR FEB 8 1967		37. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

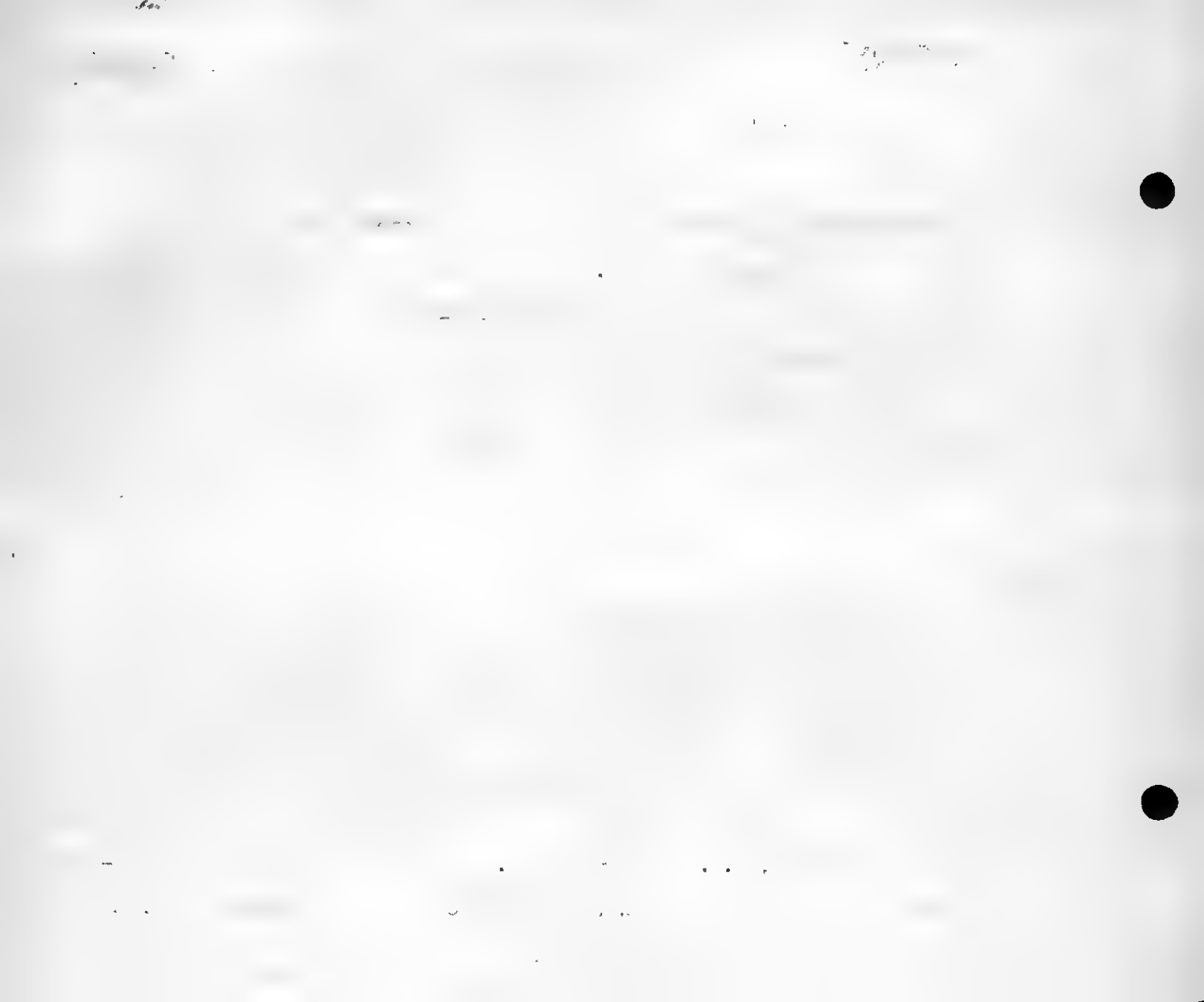
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02582

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 4516 Yates Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas E. Jones				4. DATE OF DEATH Month 2 Day 26 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1926		9. AGE (In years last birthday) 40 yrs	10. IF UNDER 1 YEAR Months 0 Days 26 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway engineer		10b. KIND OF BUSINESS OR INDUSTRY D C Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Thomas Jones				14. MOTHER'S MAIDEN NAME Rosalie America			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) W W II		16. SOCIAL SECURITY NO 215 20 3076		17. INFORMANT Address Florence Z Jones Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 525X IMMEDIATE CAUSE (a) Heart failure DUE TO Cor pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary fibrosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs over 2 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				22. DATE SIGNED 2-27-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street, city, town or county) Riverdale, Md.			
23a. BURIAL CREMATION, etc. (Specify) Burial		23b. DATE THEREOF 3/1/67		23c. NAME OF CEMETERY OR PLACE St. John's Church		23d. LOCATION (City or town) (County) (State) Beltsville P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02589

CERTIFICATE OF DEATH

02583

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, give nearest town) Chesley		c. LENGTH OF STAY IN 1b D. O. A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham Severn Rd. Bowie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS R. F. D. #1 Box 318		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) WESLEY HARGIST JONES			4 DATE OF DEATH Month Feb. Day 15 , Year 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 10, 1907	9 AGE (In years last birthday) yrs 59	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Tag & Title Service		11. BIRTHPLACE (County & State, or foreign country) Arkansas	
13. FATHER'S NAME ? Jones			12. CITIZEN OF WHAT COUNTRY? U.S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 11			16. SOCIAL SECURITY NO 264 34 9480		
17. INFORMANT Mildred K. Jones Same as #2 (wife)			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchiogenic Carcinoma DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 4/1/66 19 67 , to 2/15 , 19 67 that (I) (we) last saw the deceased alive on 2/6/67 , and that death occurred at 2/15 M, from causes and on the date stated above.					
22a. SIGNATURE Henry A. Wise		22b. DATE SIGNED 2/16/67	22c. PHYSICIAN'S NAME (Type) Henry A. Wise, M. D.		
22d. ADDRESS 13008 9th Street Bowie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE FEB 20 1967	25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02590						02584					
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Potomac, Md.</i>				c. LENGTH OF STAY IN 1b <i>2 yr</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Eleven Cedars Nursing Home</i>						d. STREET ADDRESS <i>RFD Rt 2 Box 143</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charlotte</i> Middle <i>Elizabeth</i> Last <i>KEDDY</i>						4. DATE OF DEATH Month <i>2</i> Day <i>5</i> Year <i>1967</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/24/16</i>		9. AGE (In years last birthday) <i>90</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Nova Scotia, Canada</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>						14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>215-54-8217</i>		17. INFORMANT <i>Maurice S. Keddy, Laurel, Md.</i> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ac Myocardial Failure</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arterio-sclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 1964</i> to <i>Feb 1967</i> , that (I) (we) last saw the deceased alive on <i>1/30 1967</i> , and that death occurred at <i>4:30</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>W.L. Etienne</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/6/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i>						22d. ADDRESS <i>College Park 19</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>2-8-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Md</i>		23d. LOCATION (City, town or county) (State) <i>Warner Md</i>			
24. FUNERAL DIRECTOR <i>William A. Anderson</i>						ADDRESS <i>Laurel Md</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
						DATE <i>FEB 15 1967</i>					

CERTIFICATE OF DEATH

02591

02585

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHILLUM</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d. STREET ADDRESS <u>1101 OAKDALE DR</u>	
3. NAME OF DECEASED (Type or print) <u>Rena GRACE</u> First Middle Last		4. DATE OF DEATH <u>February 7</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>71</u> yrs If UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ERNEST KIDWELL</u>		14. MOTHER'S MAIDEN NAME <u>KATIE HART</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>ROSS S. KIDWELL</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral ischemic colon</u> DUE TO (b) <u>1538</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 to <u>2/7/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/7/67</u> , 19 <u>67</u> , and that death occurred at <u>7:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitzky MD</u>		22b. DATE SIGNED <u>2/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitzky MD</u>		22d. ADDRESS <u>3408 Rd. Beland Ave. Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9 FEB 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u>	23d. LOCATION (City or town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co Riverdale, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and removed in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02592

02586

1. PLACE OF DEATH a. COUNTY Pr. Gee. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Pro Gee. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4312 Newark Road				d. STREET ADDRESS 4312 Newark Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BAILEY Middle S. Last KINCHEN				4. DATE OF DEATH Month Feb. Day 16 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 13, 1893	
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Pressman				10b. KIND OF BUSINESS OR INDUSTRY Govt. P. O.		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles Ruffin Kinchen				14. MOTHER'S MAIDEN NAME Hester Rogers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579 01 2069A		17. INFORMANT Address Louise M. Kinchen Wife Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO (b) Pulmonary Embolism DUE TO (c) Arteriosclerotic coronary artery disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH 16 days 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic coronary artery disease.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1966 to February 1967 , that (I) (we) last saw the deceased alive on Feb 17, 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. A. Wimsatt				22b. DATE SIGNED K.F. 6-1967		22c. PHYSICIAN'S NAME (Type) William. A. Wimsatt MD	
22d. ADDRESS 3415 Hamilton St Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/67		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR DATE 6-20-1967	
25b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02593

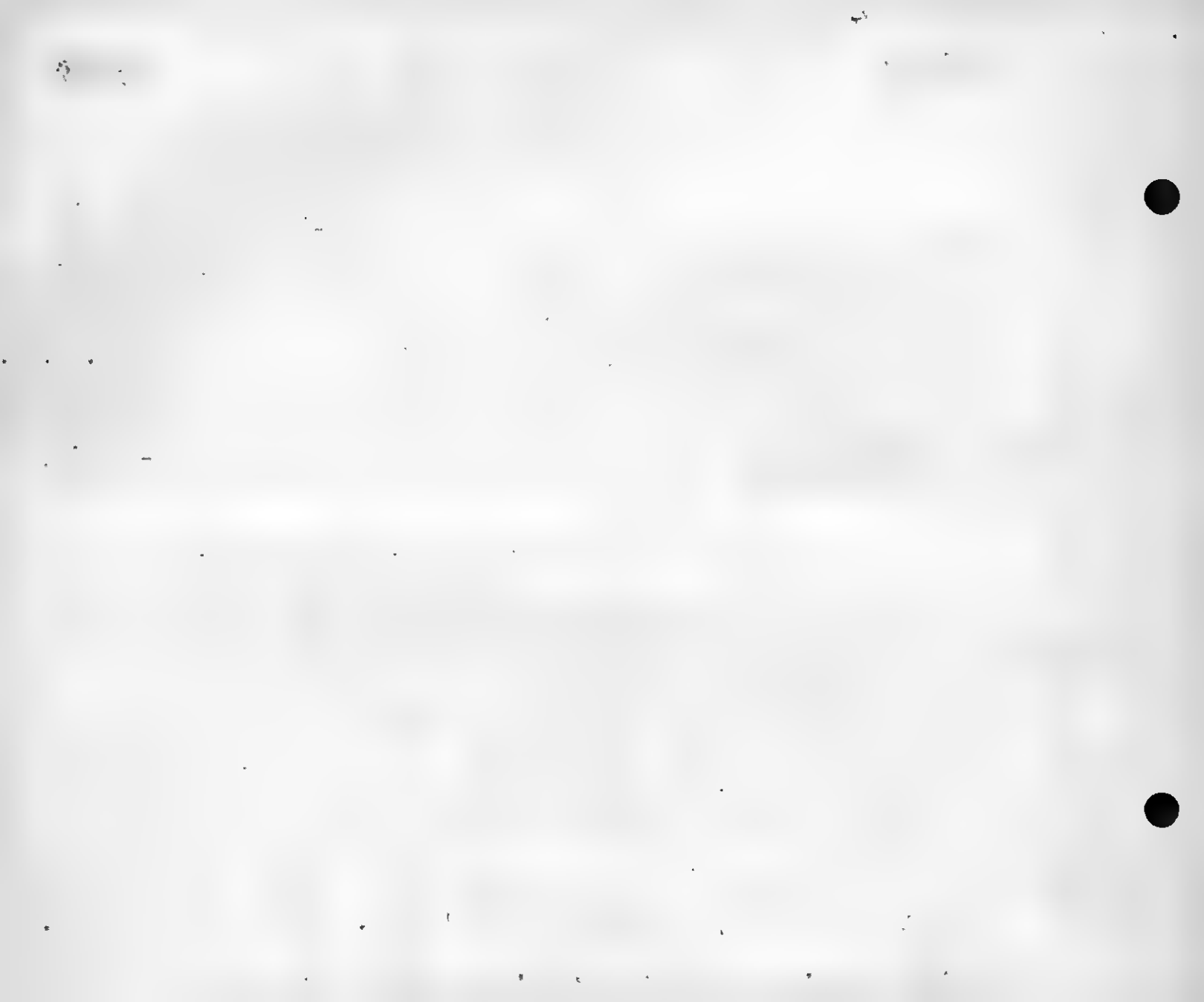
CERTIFICATE OF DEATH

02587

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 31 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Route #1, Box 1106	
3. NAME OF DECEASED (Type or print) First Middle Last Everett Lee King		4. DATE OF DEATH Month Day Year Feb. 16, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/27/07
9. AGE (In years lost birthday) 59 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward King		14. MOTHER'S MAIDEN NAME Mary Jane Linkous	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO 348 Alameda Pkwy	
17. INFORMANT Margaret Elizabeth Francis-Arnold, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Status one day post partial esophago-giastrectomy for adenocarcinoma of esophagus DUE TO (c) for adenocarcinoma of esophagus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 150h			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1967 , to Feb. 16, 1967 , that (I) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 5:40 M. from causes and on the date stated above.			
22a. SIGNATURE George William Ware		22b. DATE SIGNED 2/17/67	
22c. PHYSICIAN'S NAME (Type) George William Ware, M.D.		22d. ADDRESS 1835 Eye St NW.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/18/67	23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	23d. LOCATION (City or town) (County) (State) Suitland Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

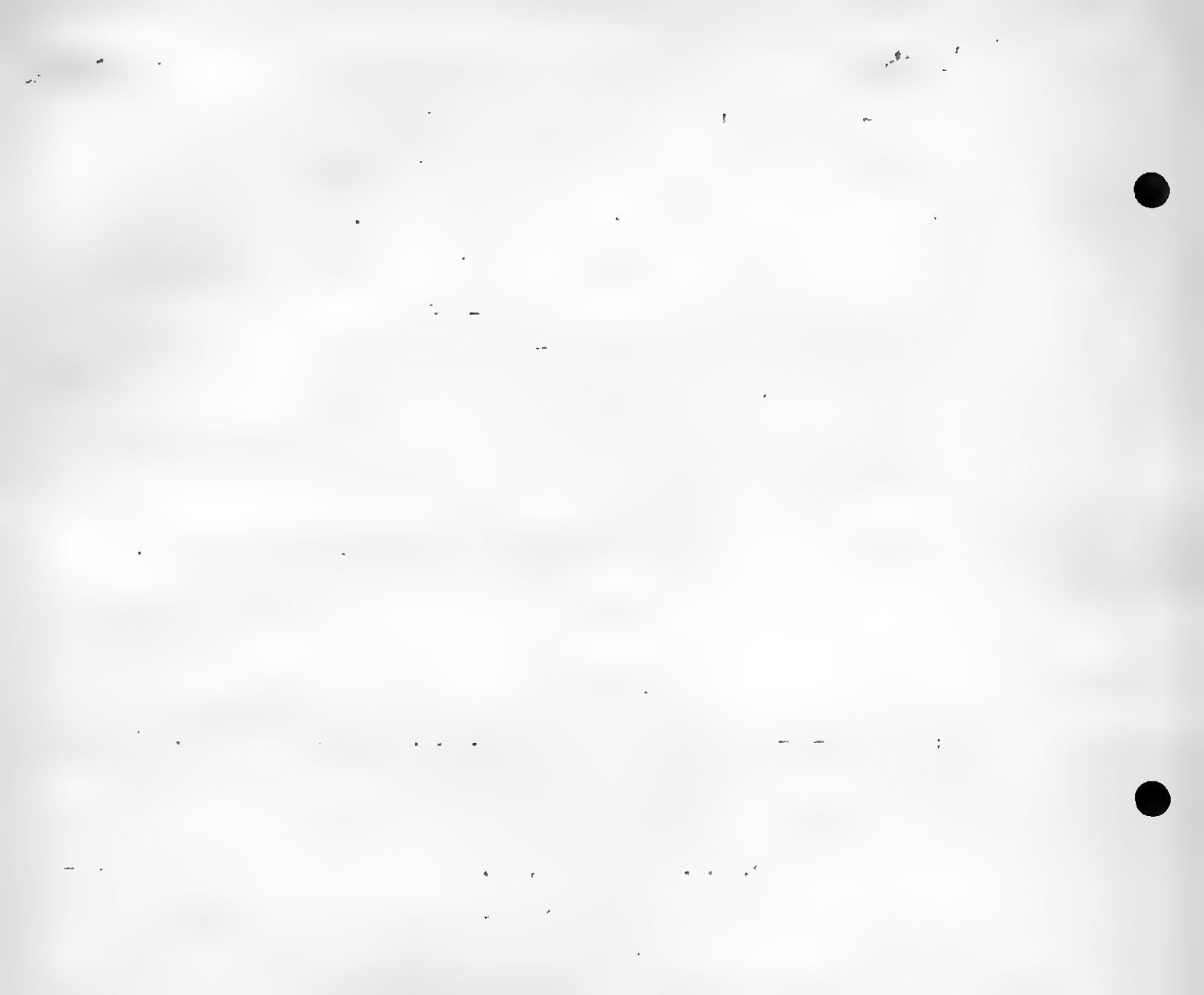
02594

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02588

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 1510 N St.	
3. NAME OF DECEASED (Type or print) First George Middle Edward Last King		4. DATE OF DEATH Month 2 Day 20 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-1942
9. AGE (In years last birthday) 25 yrs		IF UNDER 1 YEAR Months 25 Days 25 Hours 25 Min 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CECIL KING		14. MOTHER'S MAIDEN NAME PAULINE EDMONDS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT PATRICIA ANN KING		Address 2522 MARLBORO AV LANDOVER, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Decerebration 802X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) compound skull fracture (c) and multiple fractures of limbs, ribs and pelvis		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by train	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:35am pm 2-20-1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Landover, Maryland P.G. (State)		20f. (City or town) (County) (State) Penna. R.R. Tracks, 2 posts So. of Post 128,	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 2-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 23 FEB 1967	
23c. NAME OF CEMETERY OR CREMATORY MIDDLEBURG CEM		23d. LOCATION (City or Town) (County) (State) MIDDLEBURG, VIRGINIA,	
24. FUNERAL DIRECTOR W.W. CHAMBERS GO		ADDRESS RIVERDALE, MD	
25a. REC'D BY REGISTRAR FEB 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION



1 (M)

74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VER A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02595

CERTIFICATE OF DEATH

02589

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Helen Middle Marie Last King		4 DATE OF DEATH Month FEBRUARY Day 8 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 21, 1919
9. AGE (in years last birthday) 48		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elby Ralston		14. MOTHER'S MAIDEN NAME Carrie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219 03 9299	
17. INFORMANT James B King sr		Address College Park, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS - GENERALIZED DUE TO (b) CYSTADENOCARCINOMA OF THE DUE TO (c) OVARIES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOCYTOPENIC PURPURA ACQUIRED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-20-1966, to 2-8-1967, that (I) (we) lost the deceased alive on 2-7-1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE William B. Hagan M.D.		22b. DATE SIGNED 2-8-67	
22c. PHYSICIAN'S NAME (Type) William B Hagan		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City or Town) Dorsey (County) (State) Nd
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
02596		CERTIFICATE OF DEATH		02590	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 6341 Landover Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ann Middle J. Last Langtry			4. DATE OF DEATH Month Feb Day 19 Year 1967		
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-86	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lawrence, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Martin Connell		
14. MOTHER'S MAIDEN NAME Elizabeth Mulholland			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. 025-07-5430			17. INFORMANT Mr. Harvey E. Wood (Dr., Falls Ch., Va.)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO (b) HEMORRHAGE DUE TO (c) RUPTURED ABDOMINAL ANEURYSM					INTERVAL BETWEEN ONSET AND DEATH 18 HRS 18 HRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (H) (this hospital) attended the deceased from 2-18 , 19 67 , to 2-19 , 19 67 , that (H) (we) last saw the deceased alive on 2-19 , 19 67 , and that death occurred at 12:45 P.M. from causes and on the date stated above.					
22a. SIGNATURE Norman K. Bohrer			22b. DATE SIGNED Feb 20, 1967		
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M. D.			22d. ADDRESS Prince George's General Hospital		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/22/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Suitland, Maryland		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02597

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02591

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Reside in institution) <input checked="" type="checkbox"/> a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d STREET ADDRESS 10004 Crestwood Road	
3 NAME OF DECEASED (Type or print) William Francis Lawrence		4 DATE OF DEATH 2 15 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (in years last birthday) 51
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY Keebler Biscuit	
11 BIRTHPLACE (State or foreign country) Albany, New York		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME DeWitt Lawrence		14 MOTHER'S MAIDEN NAME Louise Wilde	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO 577-03-0564	
17 INFORMANT Paul J. Clarke		Address 6841 Trexler Rd., Lanham Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery thrombosis, left anterior descending			
DUE TO (b) minutes			
DUE TO (c) minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 2-16-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 18 Feb. 1967	
23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION (City or town) (County) (State) Silver Spring, Md.	
24 FUNERAL DIRECTOR Rinaldi Funeral Home, Inc.		ADDRESS DC 20012	
25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge	
FEB 20 1967			

FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

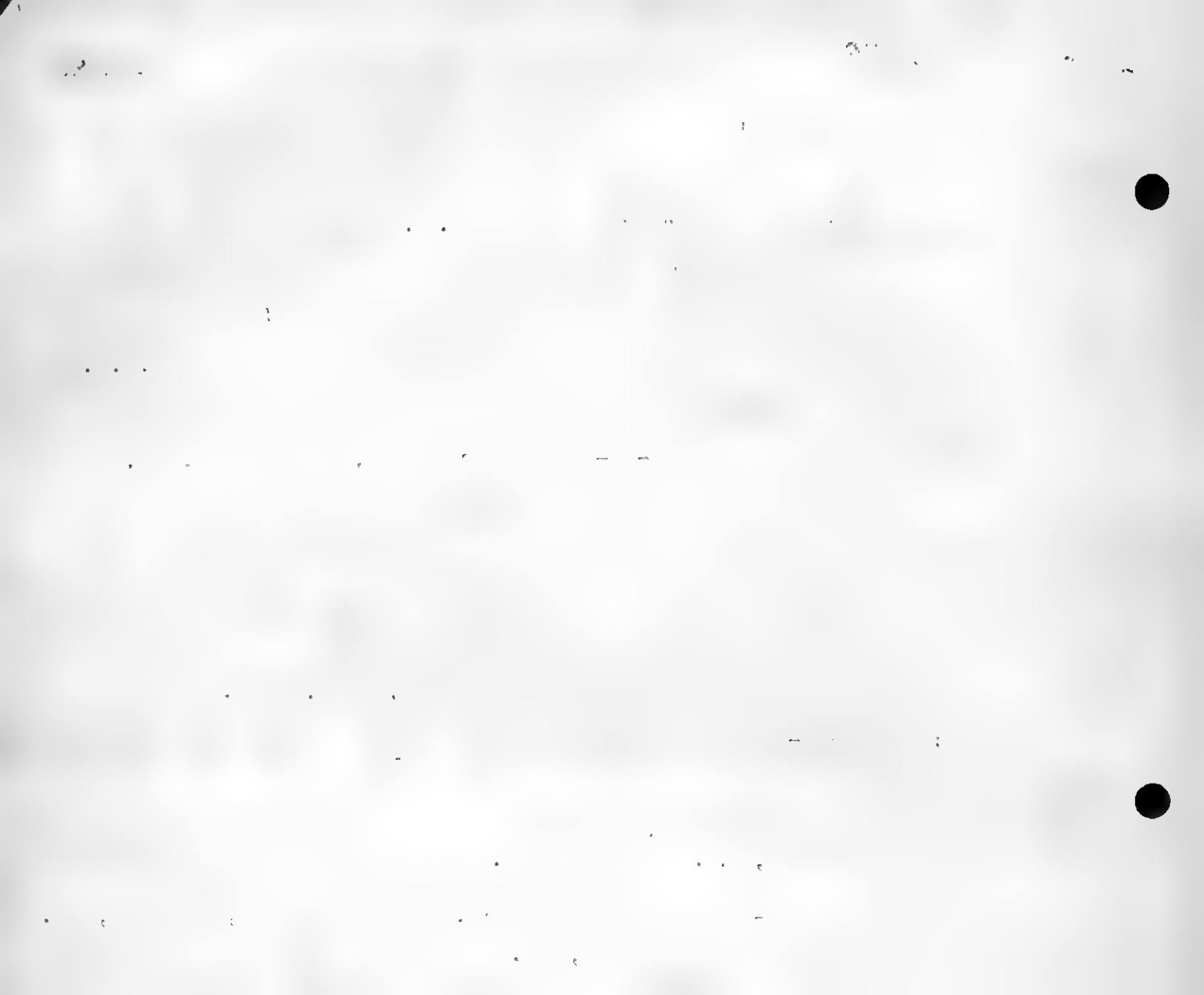
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY N 1b DOA		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Brandywine 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital			d. STREET ADDRESS Rt. 1, Box 364		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) Alexander Louis Letcher			4 DATE OF DEATH Month 2 Day 27 Year 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 March 1913	9 AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months 27 Days 19 Hours 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storeclerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11 BIRTHPLACE (State foreign country) Maryland	
12 C. T. ZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME Alexander Letcher		
14 MOTHER'S MAIDEN NAME Pauline Veneka			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		
16 SOCIAL SECURITY NO 578-03-4936		17 INFORMANT Betty Ellis, Brandywine, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of brain 7 16 X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self thru palate with .22 cal. rifle.			
21 TIME OF INJURY Month Day Year Hour am pm 1:00am 2-27-1967		22a. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> of work of work Home		22b. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Same as #2	
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-27-67		23a. REC'D BY REG STRK 6 MAR 6 1967	
EXAMINER'S NAME (Type) John Kehoe, M.D.		23b. DATE THEREOF 3-2-67		23c. NAME OF CEMETERY OR CREMATORY St Peters Cem.	
23d. LOCATION (City or town) (County) (State) Waldorf, Charles, Md.		24 FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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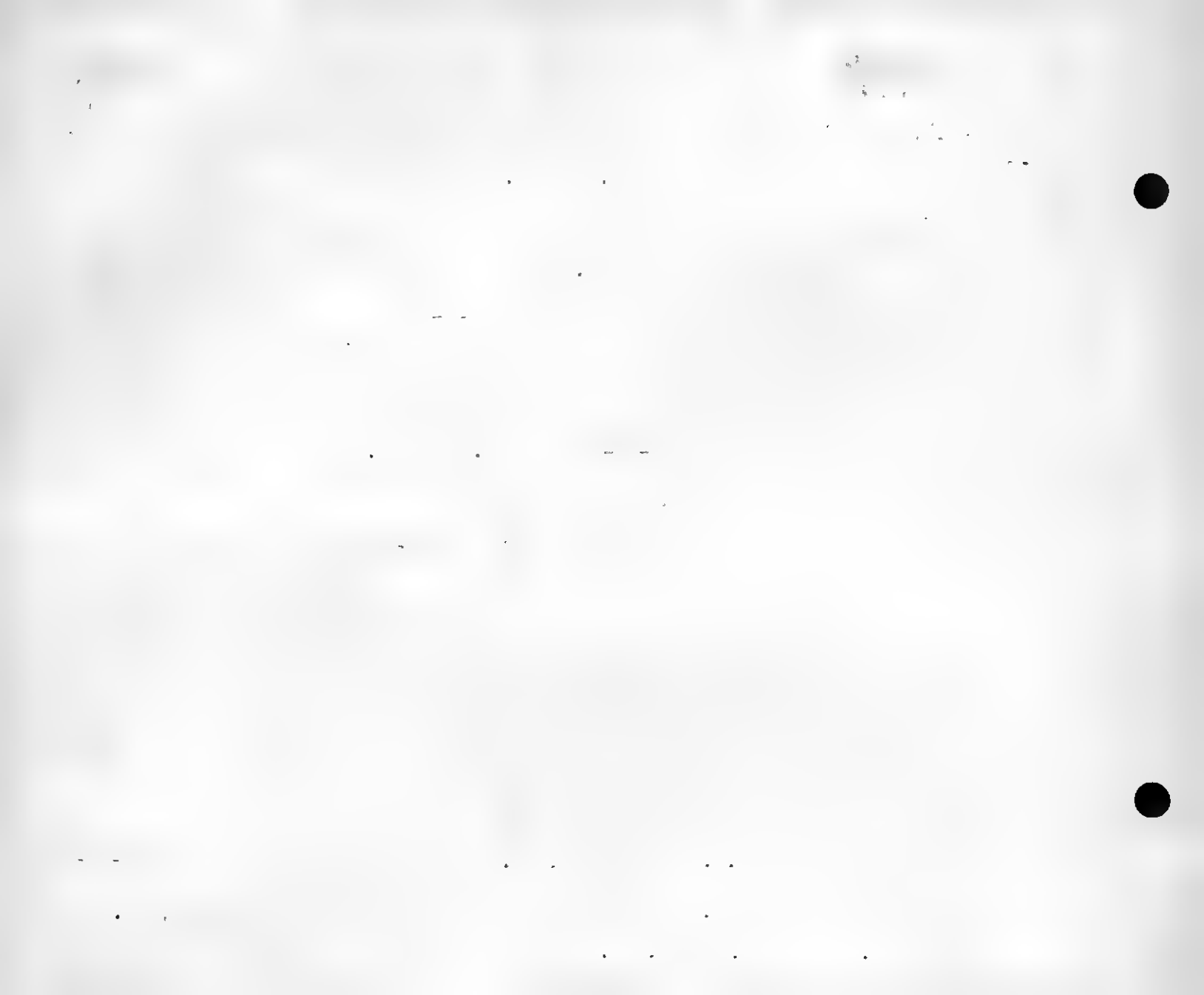
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02599

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02593

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN 1b 2hrs. 25 min.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 7204 Rolling Ridge Drive	
3. NAME OF DECEASED (Type or print) Hattie M. LeVee		4 DATE OF DEATH Month 2 Day 22 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-9-1881
9 AGE (in years lost birthday) 86 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Charles Lynn	
14 MOTHER'S MAIDEN NAME Frances Holland		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 715-03-1549D		17 INFORMANT Mrs. Alice L. DeMar	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO And uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) Due to Generalized arteriosclerosis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-23-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	2/25/67.	Baltimore Cemetery	Baltimore, Md.
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a RECD BY REGISTRAR FEB 27 1967	
25b REGISTRAR'S SIGNATURE Charles J. J...			



02600

CERTIFICATE OF DEATH

02594

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Andrews AFB Springs</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USAF Hospital Andrews</u>		d. STREET ADDRESS <u>4922 Temple Hills Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Edward Long</u>		4. DATE OF DEATH <u>February 25 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1888</u>
9. AGE (n years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired US Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>China Grove, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S Long</u>		14. MOTHER'S MAIDEN NAME <u>Ester Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI & II</u>		16. SOCIAL SECURITY NO. <u>579-05-5919</u>	
17. INFORMANT <u>Mrs. T. E. Goodwin (Dau)</u>		Address <u>4922 Temple Hills Rd Temple Hills, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Passive Congestion of Heart</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 19, 1967</u> , to <u>Feb. 25, 1967</u> , that (I) (we) lost the deceased alive on <u>Feb 25 1967</u> , and that death occurred at <u>2:00</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>O. E. Langdon</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>25 Feb 67</u>
22c. PHYSICIAN'S NAME (Type) <u>O. E. LANGDON, LtCol, MC, USAF</u>		22d. ADDRESS <u>USAF HOSPITAL ANDREWS ANDREWS AFB</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		ADDRESS <u>WASH. D.C.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02601

CERTIFICATE OF DEATH

02595

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 6308 60th Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Viola S. Loyd		4 DATE OF DEATH Month 2 Day 26 Year 1967	
5. SEX Female	6. CO. OR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-9-02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCC. PAT ON (Give kind of work done during last 12 months, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) N. Carolina - Warren Co.
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Walter Stevenson	
14. MOTHER'S MAIDEN NAME Lena Hopkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 241 68 7048		17. INFORMANT James Loyd, 6860 Riverdale Rd., Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO GEN. ARTERIOSCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN (c)		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-20 , 19 67 , to 2-26 , 19 67 that (I) (we) last saw the deceased alive on 2-26 , 19 67 , and that death occurred at 8:10 AM , from causes and on the date stated above			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 2-26-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 2/28/67	23c. NAME OF CEMETERY OR CREMATORY Fairview	23d. LOCATION (City or Town) (County) (State) Warrington Warren Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02602

CERTIFICATE OF DEATH

02596

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 16 2 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 10401 - A - 46th Ave.	
3 NAME OF DECEASED (Type or print) First Russell Middle R. Last Marsh		4. DATE OF DEATH Month Feb. Day 26, Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 14, 1910
9 AGE (In years last birthday) 56 yrs		10 UNDER 1 YEAR Months 1 Days 24 Hours 19 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b KIND OF BUSINESS OR INDUSTRY construction	
11 BIRTHPLACE (County & State, or foreign country) Albermarle County Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Marsh		14. MOTHER'S MAIDEN NAME Lillie Madison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16 SOCIAL SECURITY NO 230 03 6475	
17 INFORMANT Russell Marsh Jr		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute coronary occlusion, Rt main coronary art. 1101 -DUE TO with (b) congestive heart failure -DUE TO with (c) with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Glomerulonephritis, Bicuspid Aortic Valve			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Feb. 24, 19 67, to Feb. 26, 19 67, that (we) last saw the deceased alive on Feb. 26, 19 67, and that death occurred at 04:40 P.M. from causes and on the date stated above			
22a SIGNATURE Frederick H. Wilhelm		22b DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.		22d ADDRESS 6311 Landover Road, Cheverly Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF March 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 3 1967	
		25b REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02603

CERTIFICATE OF DEATH

02597

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
3. NAME OF DECEASED (Type or print) First Baby Middle Roy Last Mason		4. DATE OF DEATH Month Feb Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Feb. 1967
9. AGE (In years lost birthday) yrs. 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Sibney Mason	
14. MOTHER'S MAIDEN NAME Alice Cecilia Jenkins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address As above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7625 IMMEDIATE CAUSE (a) Asphyxiation DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1967 , to Feb. 3, 1967 , that (I) (we) last saw the deceased alive on Feb. 3, 1967 , and that death occurred 8:30 AM from causes and on the date stated above.			
22a. SIGNATURE John Perkins		22b. DATE SIGNED 2-4-67	
22c. PHYSICIAN'S NAME (Type) John Perkins, M.D.		22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 2/11/67	23c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp.	23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland		25a. REC'D BY REGISTRAR DATE FEB 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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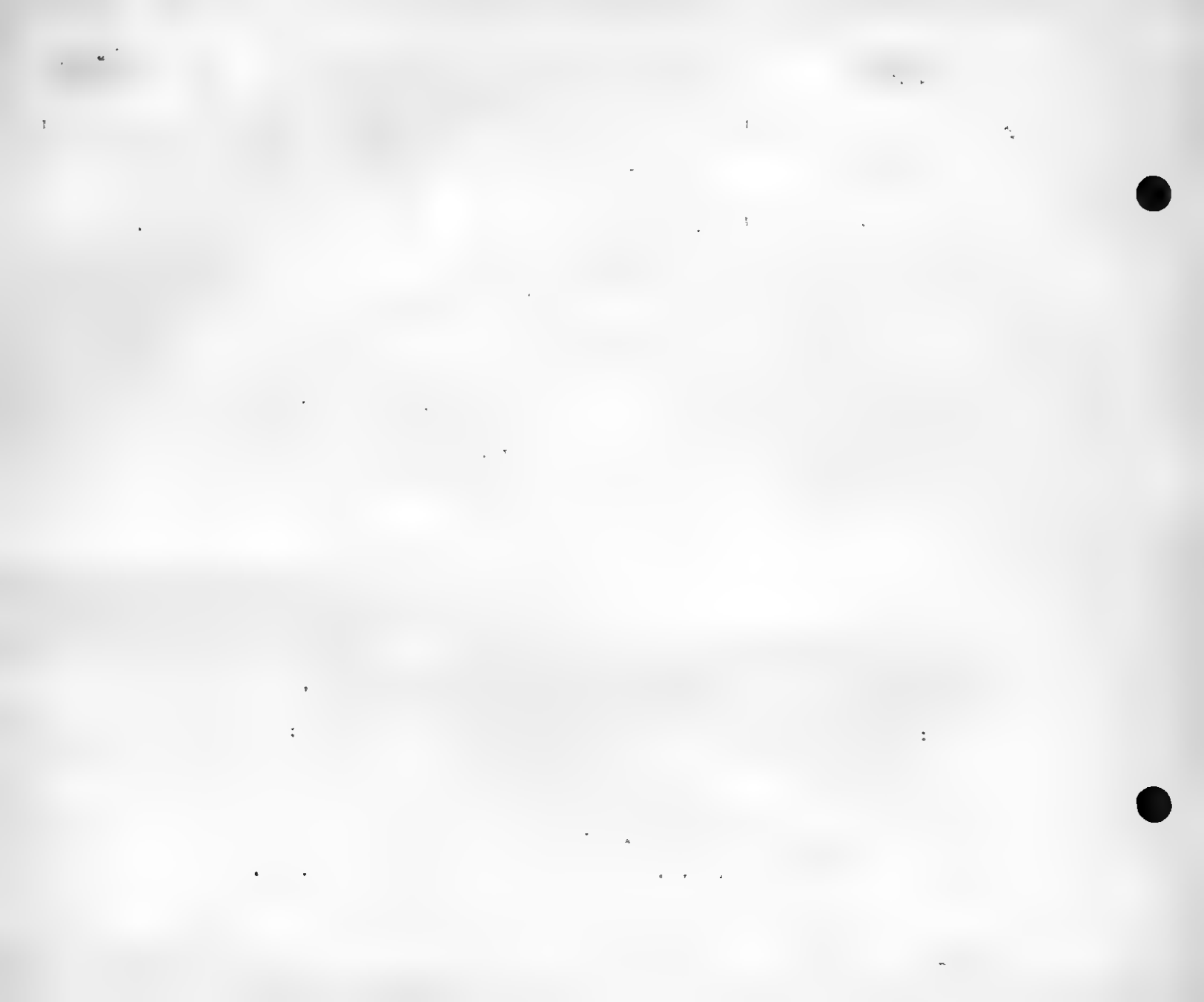
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02604

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02598

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Huston Mathis		4 DATE OF DEATH Month February Day 25 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 28, 1964
9 AGE (In years last birthday) 2 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---	
10b KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (State or foreign country) Baltimore, Md.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Sammy M. Mathes	
14 MOTHER'S MAIDEN NAME Kasandra Grindstaff		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO ---		17 INFORMANT Address Parents, (same as #2)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Inhalation of smoke 7160 SMOK AND Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Burns - 90% of body surface (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH minutes minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Burned in fire of unknown origin.			
20c TIME OF INJURY Month, Day, Year 7:50am 2-25-67		20d INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Storage room of home: same as # 2	
20e PLACE OF INJURY (Home, farm, factory, street, outside building, etc.) Storage room of home: same as # 2		20f (City or town) (County) (State) Annopolis Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address Riverdale, Md.	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF Feb. 28, 1967	23c NAME OF CEMETERY OR CREMATORY Steelecrest Cemetery	23d LOCATION (City or town) (County) (State) Annopolis Md
24 FUNERAL DIRECTOR Arthur Walters		25 REC'D BY REGISTRAR Charles Judge	
25b REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 28 1967	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02605

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02599

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d STREET ADDRESS 6908 Heidelberg Road	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Harry				4 DATE OF DEATH Month 2 Day 1 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 14 Feb. 1923		9 AGE (In years lost birthday) 43 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept of Agriculture		10b KIND OF BUSINESS OR INDUSTRY U S Government		11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Charles Mc Manus				14 MOTHER'S MAIDEN NAME Elizabeth Warren			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) yes		16 SOCIAL SECURITY NO W 11		17 INFORMANT Audrey L. Mc Manus		Address Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 161X DUE TO Occlusion of airway Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) From Carcinoma of larynx DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D.				22. DATE SIGNED 2-2-67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb 3, 1967		23c NAME OF CEMETERY OR CREMATOR Arlington National		23d LOCATION (City or Town) (County) (State) Arlington Virginia	
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR Feb 6 1967	
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #3385 2-5-67

02606

CERTIFICATE OF DEATH

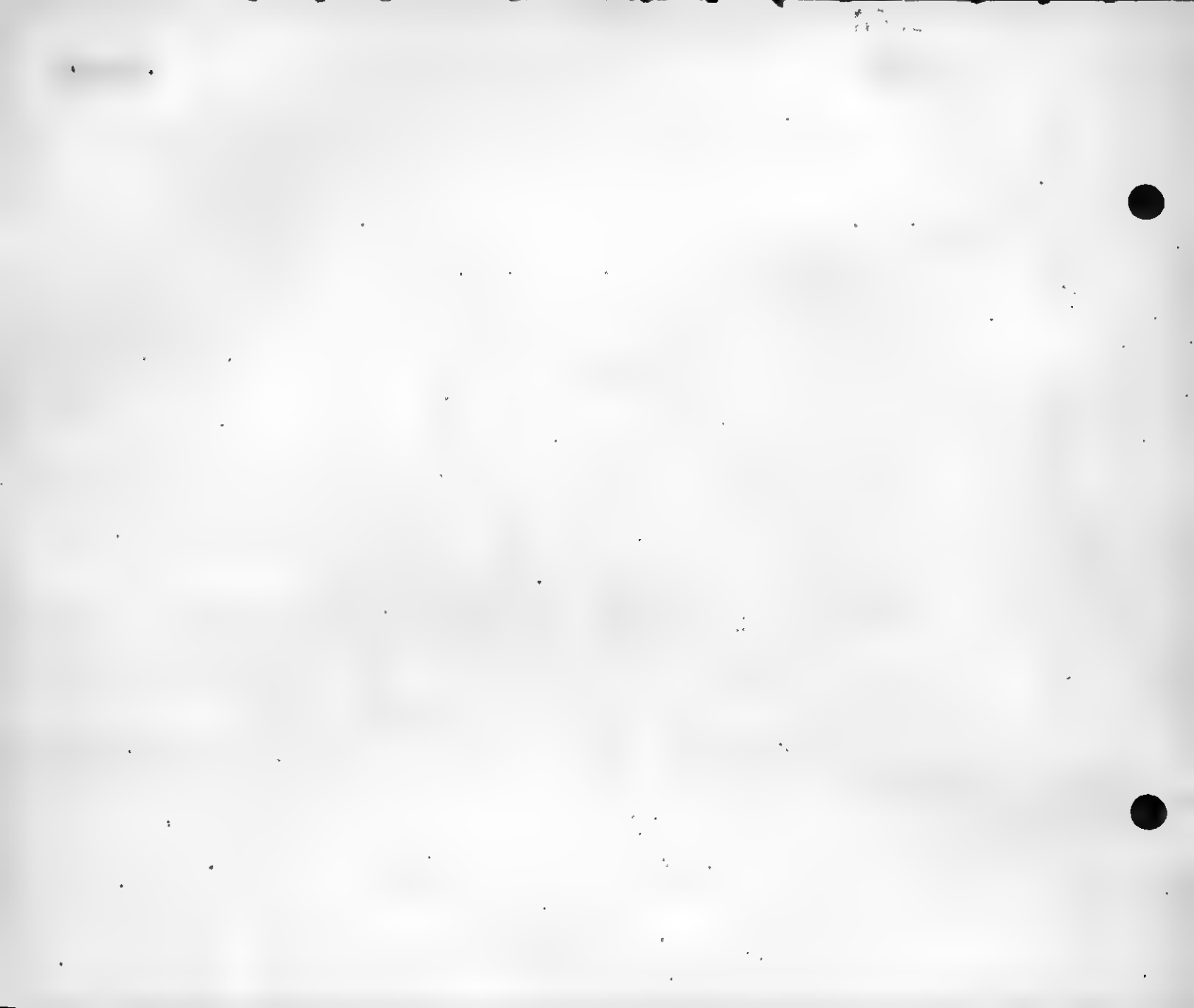
02600

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 60 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS xx		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) John McPherson			4. DATE OF DEATH Month Feb Day 7 Year 1967		
5 SEX Male	6. COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/4/66/02		9 AGE (In years last birthday) 64 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY School	11 BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Frank McPherson			14 MOTHER'S MAIDEN NAME Elizabeth Norris		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 214-14-4595	17 INFORMANT 3400 Auchentoroly Terr. Fredrick McPherson-Brother, Baltimore		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Gen. arteriosclerosis Heart Disease					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from 12-9 , 19 66 , to 2-7 , 19 67 , that (I) (we) last saw the deceased alive on 2-7 , 19 67 , and that death occurred at 11:30 PM , from causes and on the date stated above					
22a. SIGNATURE J. A. Garcia, M.D.		22b. DATE SIGNED 2/9/67		22c. PHYSICIAN'S NAME (Type) J. A. Garcia, M.D.	
22d. ADDRESS Prince George's General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/14/1967	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City or Town) (County) (State) La Plata, Maryland		
24 FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR DA FEB 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02607 CERTIFICATE OF DEATH 02601

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Marlow Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Prince George		d. STREET ADDRESS 3817 St. Barnabas Road	
3. NAME OF DECEASED (Type or print) First Middle Last Lorena V. Meholek		4. DATE OF DEATH Feb Month 21 Day 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-16-1896	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (County & State, or foreign country) Washin-ton, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Hunwood		14. MOTHER'S MAIDEN NAME Mary Goldsborough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579 10 9715	
17. INFORMANT John Meholek		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocard infarct 11/2/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. Atherosclerosis (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH Known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. off 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July, 1965, to Feb 10, 1967, that (I) (we) last saw the deceased alive on Feb 10, 1967, and that death occurred at 11 PM, from the causes and on the date stated above.		22a. SIGNATURE Laszlo K. Csatory MD	
22b. DATE SIGNED 2-21-67		22c. PHYSICIAN'S NAME (Type) Laszlo K. Csatory MD.	
22d. ADDRESS 1503 Good Hope Rd. S.E. Wash.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland, Md	
24. FUNERAL DIRECTOR Robert A. Mattingly		25a. REC'D BY REGISTRAR 131-1128883	
25b. REGISTRAR'S SIGNATURE Charles J. ...		25c. DATE FEB 23 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~When~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

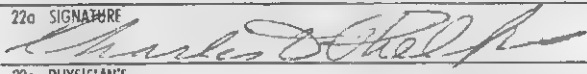

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02608

CERTIFICATE OF DEATH

02602

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN TB 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2 USUAL RESIDENCE (Where deceased lived, if he institut an Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO d. STREET ADDRESS 6515 ROSEMONT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARY FRANCIS MEHRER First Middle Last		4. DATE OF DEATH FEBRUARY 6 19 67 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 APR 1894
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) FLORENCE, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THEODORE A. GIBBS		14. MOTHER'S MAIDEN NAME MINNIE APPLGATE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT MILTON A. MEHRER-SON-SAME AS #2 ABOVE Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN		INTERVA. BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS AND HYPERTENSION		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4 FEB , 1967, to 6 FEB , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 FEB , 1967, and that death occurred at 11:30 from causes and on the date stated above.			
22a. SIGNATURE  M.D.		22b. DATE SIGNED 11:20 A.M. 6 FEB 1967 M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/9/67	
23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY		23d. LOCATION (City or Town) (County) (State) BURLINGTON, NEW JERSEY	
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND ADDRESS		25a. REC'D BY REGISTRAR FEB 10 1967 DATE	
25b. REGISTRAR'S SIGNATURE 			

02603

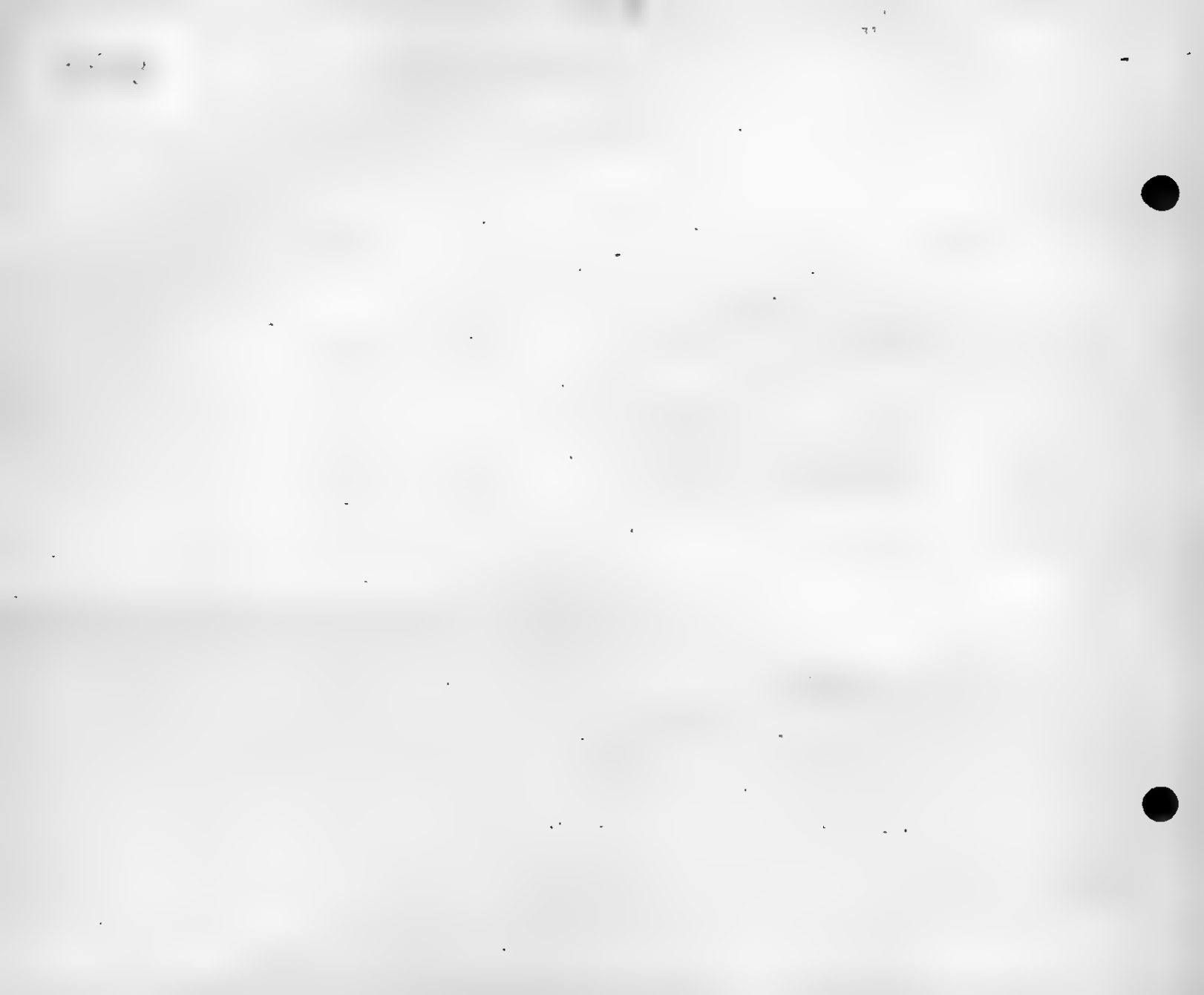
CERTIFICATE OF DEATH

02603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm-ssion) a. STATE <u>M.D.</u> b. COUNTY <u>P.R.G.E.D.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BRANDYWINE</u>	
c. LENGTH OF STAY IN 1b <u>16 HRS.</u>		d. STREET ADDRESS <u>RT 2 BOX 257-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SOUTHERN MARYLAND HOSP. CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Edith</u> Last <u>MUDD</u>		4 DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>19 67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/16/196</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>Bernard Albert Mudd</u>		14. MOTHER'S MAIDEN NAME <u>Frances Edith Middleton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-3545</u>	
17. INFORMANT <u>Grace Mudd</u>		Address <u>Upper Marlboro, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>DIABETIC ARTERIO-SCLEROTIC CV</u> DUE TO (c) <u>10 YRS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18) <u>None</u>	
20c. TIME OF INJURY Month Day, Year <u>None</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, etc., building, etc.) <u>None</u>
20f. (City or town) <u>None</u> (County) <u>None</u> (State) <u>None</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 19 57</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>FEB. 17 19 67</u> , and that death occurred at <u>4:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		22b. DATE SIGNED <u>2/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8805 BRANCH AVE. - CLINTON, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wt. Carmel</u>	23d. LOCATION (City or Town) (County) (State) <u>Upper Marlboro, B. Geo. MD</u>
24. FUNERAL DIRECTOR <u>The Herrett Funeral Home, St. Adolph, Md</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02610					02604						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Prince Georges MARYLAND					a. STATE Maryland b. COUNTY Pr. Geo.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6507 C Street					d. STREET ADDRESS 6507 C Street						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First CORA		Middle L.		Last MULLICAN		4. DATE OF DEATH		
									Month Day Year		
									Feb. 2 1967		
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1902		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wentz					14. MOTHER'S MAIDEN NAME Loretta McMasters						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Spencer R. Mullican		Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5310 Cirrhosis, Rxn Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HE EXTENSIVE CHRONIC MEDICAL DISEASE, MYOCARDIAL ISCHEMIA/DIABETES 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1956, 19, to 7/2, 1967, that (I) (we) last saw the deceased alive on 1/25 1967, and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Thomas Mullican										22b. DATE SIGNED 2-2-67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen					22d. ADDRESS 5808 Maryland Ave SE. Over						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/6/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City, town or county) (State) Colmar Manor Maryland				
24. FUNERAL DIRECTOR J. Wm. Lees Sons, 300 4th St NE, Wash., DC					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		

02611

CERTIFICATE OF DEATH

02605

1 PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Pro Geo	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md.	c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Nursing Home		d. STREET ADDRESS Box 151	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) MARY C. MULLIKIN		4. DATE OF DEATH Month FEBRUARY Day 6 Year 1967	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19, 1871
9. AGE (n years last birthday) 95 yrs.		IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Martin	
14. MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. --		17. INFORMANT Leo C Mullikin Edmonston, Md.	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4331 IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS UNKNOWN DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MODERATE DEHYDRATION			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 30, 1967 , to FEB 6, 1967 , that (I) (we) last saw the deceased alive on FEB 5, 1967 , and that death occurred at 7:25 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Howard M. Tanning		22b. DATE SIGNED FEB 6, 1967	
22c. PHYSICIAN'S NAME (Type) HOWARD M. TANNING, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/8/67	23c. NAME OF CEMETERY OR CREMATORY Ascension Catholic	23d. LOCATION (City or Town) (County) (State) Bowie Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Md.	
25b. REGISTRAR'S SIGNATURE DATE FEB 10 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in capital in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02612

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02606

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If acts de corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If acts de corporate limits, write RURAL and give nearest town) Morningside			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5613 Regina Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Imogene Mullins				4. DATE OF DEATH Month Day Year 2 9 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-58		9. AGE (In years last birthday) 8 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry F. Mullins				14. MOTHER'S MAIDEN NAME Hilda I. Redden			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT James C. Mullins 6236 Dallas Pl. Temple Hill			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9250 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Trapped in trunk DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) lid of trunk closed and locked with child in trunk					
20c. TIME OF INJURY Hour a.m. Month, Day, Year P.M. p.m. 2-9 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Morningside P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D. Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22. DATE SIGNED 2-10-67							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland Maryland				25a. REC'D BY REG STRAR DATE FEB 15 1967		25b. REG STRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02613

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2, 10a, 14, 15, 16 Film G385 2/15/67 mh

CERTIFICATE OF DEATH

02607

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>4604 Knox Rd., Apt. 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert R.</u> Middle <u>Mumford</u> Last <u>Mumford</u>				4. DATE OF DEATH <u>Feb.</u> Month <u>5</u> Day <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Electro Chemical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Research Electro Chemical Engineer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles N. Mumford</u>				14. MOTHER'S MAIDEN NAME <u>Albertina V. Shupe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI 11</u>		16. SOCIAL SECURITY NO. <u>057-09-4541</u>		17. INFORMANT <u>Mrs Cora M. Mumford Same as D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4:01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 weeks</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatic heart disease, gastric ulcer, diabetes mellitus</u>						19. WAS A TAPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 22, 1967</u> , to <u>Feb. 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5, 1967</u> , and that death occurred at <u>1:25 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William B. Gunther</u>		22b. PHYSICIAN'S NAME (Type) <u>William B. Gunther, M. D.</u>		22c. ADDRESS <u>4917 Edgewood Rd. College Park Md.</u>		22d. DATE SIGNED <u>Feb. 6, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home Washington DC</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

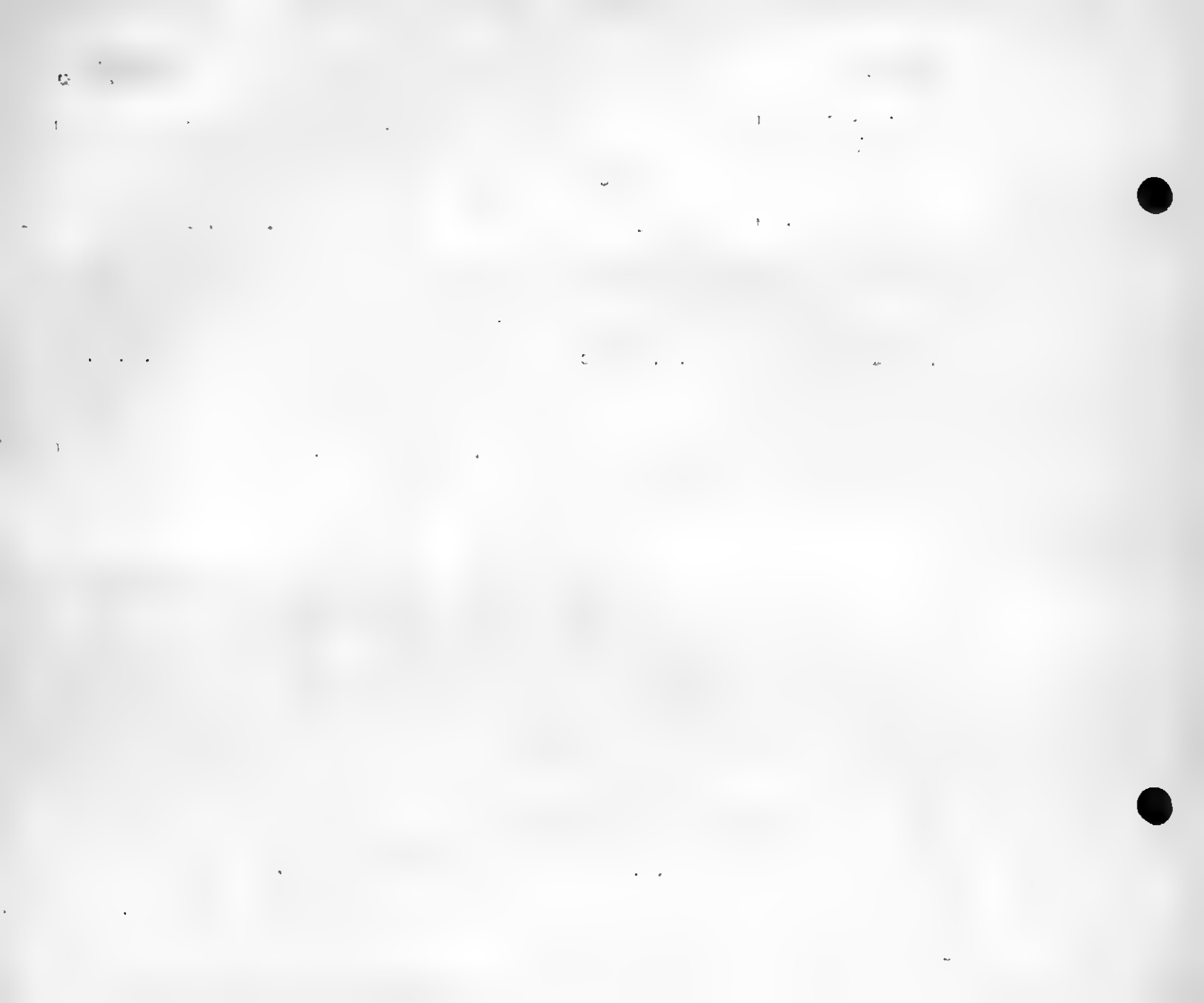
02614

02608

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				d. STREET ADDRESS 3115 75th Ave. Apt. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Samuel George Myers				4 DATE OF DEATH Month Day Year February 19 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1908 June 20, 1908	9 AGE (In years last birthday) 58 yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of year on which death occurred) Ret. Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11 BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Bynum Lee Myers				14 MOTHER'S MAIDEN NAME Rebecca Combs			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO 578 12 9947		17 INFORMANT Address Mrs. Margaret G. Myers Same as #2 (wife)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) over 2 yrs							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Rivendale, Md.		22. DATE SIGNED 2-19-67	
23a. BURIAL, CREMATION, OR OTHER METHOD (Specify) Burial		23b. DATE THEREOF 2/22/67		23c. NAME OF CEMETERY OR PLACE OF INTERMENT Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. RECD BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE J. C. Campbell	



02615

CERTIFICATE OF DEATH

02609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capital Heights d. STREET ADDRESS 415 59th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William L. Nalley		4. DATE OF DEATH Month Day Year Feb. 18 87	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 April 1905
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days 18 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROBBER & SIDING		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Nalley		14. MOTHER'S MAIDEN NAME LENA NOTHEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-09-0825	
17. INFORMANT FLORENCE M. NALLEY		Address 4900 You St. N.W. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC BRONCHITIS + EMPHYSEMA. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 19 , to 19 , that (H) (we) last saw the deceased alive on 19 , and that death occurred at 11:15 AM from causes and on the date stated above.			
22a. SIGNATURE Norman K. Bohrer M.D.		22b. DATE SIGNED Feb 20, 1967	
22c. PHYSICIAN'S NAME (Type) NORMAN K. BOHRER		22d. ADDRESS 3231 Superior LA. Bowie, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 22 1967	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR W. W. CHAMBERS Co.		25a. REC'D BY REGISTRAR RIVERDALE, MD.	
25b. REGISTRAR'S SIGNATURE W. W. Chambers Co.		DATE FEB 27 1967	



02616

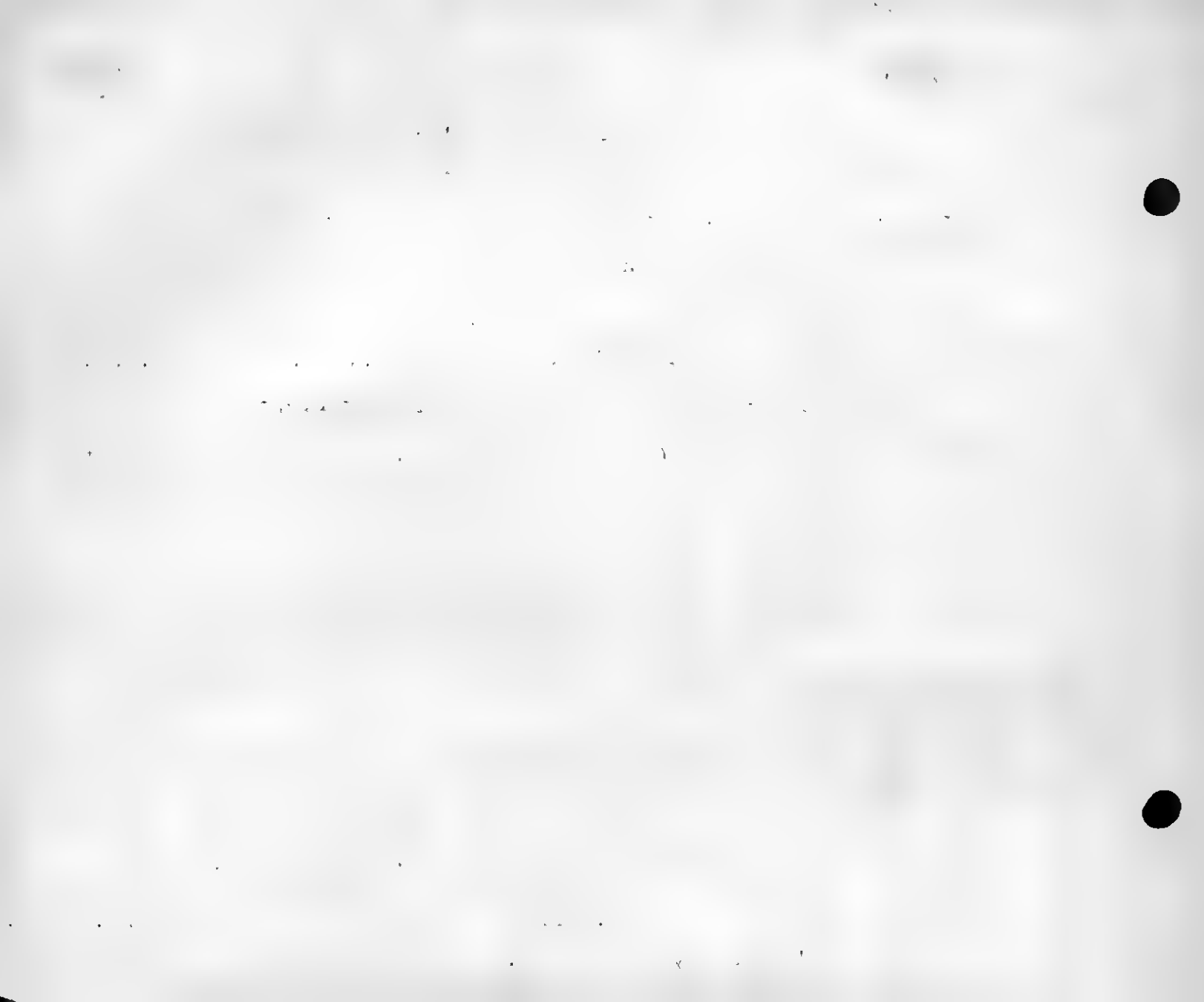
CERTIFICATE OF DEATH

02610

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 108 Lynbrook Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Leonard Nelson		4. DATE OF DEATH Month Day Year Feb. 15 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/04
9. AGE (In years last birthday) 62 yrs.		10. CIT ZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Cartographer		10b. KIND OF BUSINESS OR SERVICE Map Service	
11. BIRTHPLACE (County & State, or foreign country) Talbot Co., Md.		12. CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Elmer Nelson		14. MOTHER'S MAIDEN NAME Agnes Alma Leonard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577 18 9372	
17. INFORMANT Bernice G. Nelson Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Ischemic heart disease (Coronary artery disease) Cerebral Vascular Accident Hypertensive Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 12 days 2 years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 19 67 to Feb. 15, 19 67 that (I) (we) last saw the deceased alive on Feb. 14, 19 67 and that death occurred at 10:11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Hans Wodak		22b. DATE SIGNED 2-15-1967	
22c. PHYSICIAN'S NAME (Type) Hans Wodak, M.D.		22d. ADDRESS Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/18/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02617

CERTIFICATE OF DEATH

02611

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 mo. 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 768 Morton St., N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last Hudson N. Newberry		4. DATE OF DEATH Month Day Year 2 - 16 - 1967	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Austin Newberry		14. MOTHER'S MAIDEN NAME Annie Glave	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) Cirrhosis of Liver			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia, right lung; Ascites, Chronic Pyelonephritis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/23/1966 , to 2/16/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/16/1967 , and that death occurred on 12-15 PM from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/16/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2-20-67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.	23d. LOCATION (City or Town) (County) (State) Smithland H. Md.
24. FUNERAL DIRECTOR H.S. Washington & Son 4435 Darn Lane		25a. REC'D BY REGISTRAR DATE FEB 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02618

CERTIFICATE OF DEATH

02612

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 53 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 2800 Gaither Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eileen Middle C. Last Noland		4. DATE OF DEATH Month February Day 24 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8/28/01		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter M. Fogarty		14. MOTHER'S MAIDEN NAME Margaret Renehan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. William G. Noland, Same As # 2		17. INFORMANT Same As # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma, cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 1 wk 6 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 55 , to 2/24 , 19 67 , that (I) (we) last saw the deceased alive on 2/24 , 19 67 , and that death occurred at 7:10 M, from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Mugmon		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) LEO H. MUGMON MD		22d. ADDRESS 2711 GAITHER ST. HIGGS BL					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			
23d. LOCATION (City, town or county) Prince Georges, Maryland							
24. FUNERAL DIRECTOR Wilhelm Funeral		ADDRESS Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR FEB 28 1967			
25b. REGISTRAR'S SIGNATURE J. Charles Judge							



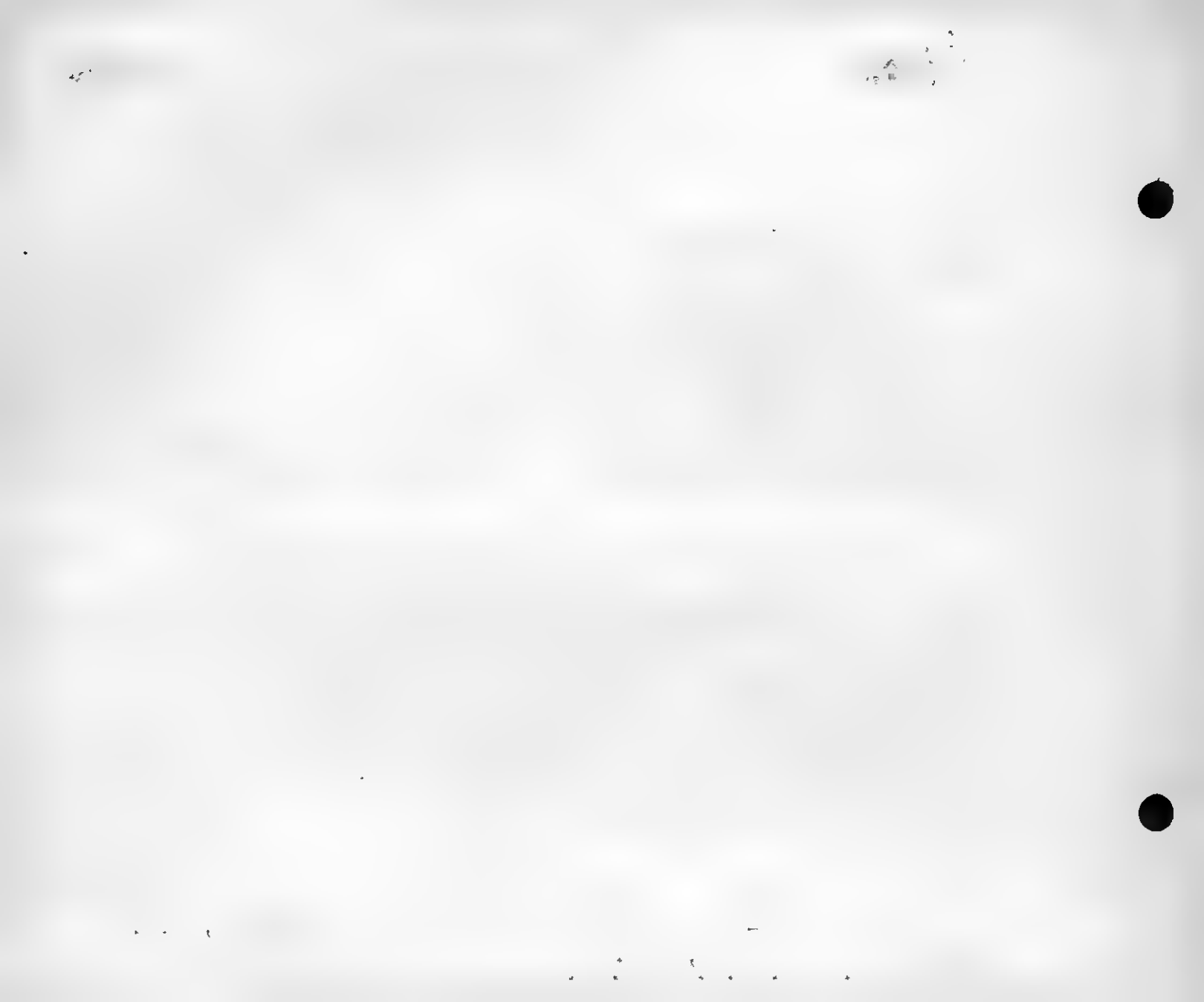
02619

CERTIFICATE OF DEATH

02613

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> DC <u>- Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>		e. STREET ADDRESS <u>200 Connecticut Ave.</u> <u>6500 Riggs Road, Aft. 109</u>	
3. NAME OF DECEASED (Type or print) First <u>EVAN</u> Middle <u>F.</u> Last <u>Norman</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul 30 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Faran</u>		14. MOTHER'S MAIDEN NAME <u>Blanche C. Coe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Lee Johnson - 806-17 St. N.W. WASH. DC</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA; RESPIRATORY ARREST</u> DUE TO (b) <u>PARKINSON'S DISEASE (SEVERE)</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PYELONEPHRITIS; POST OPERATIVE MISTECTOMY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> , 19 <u>65</u> , to <u>2/12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u>		22b. DATE SIGNED <u>2/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER M.D.</u>		22d. ADDRESS <u>911 SILVER SPRING AVE, SILVER SPRING</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>2-15-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Randolph Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Randolph, N.Y.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Blanche C. Coe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only one event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02620

CERTIFICATE OF DEATH

02614

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 6 days		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 7304 Good Luck Road			
3. NAME OF DECEASED (Type or print) First Dorothy Middle E Last Paulino						4. DATE OF DEATH Month Feb. Day 3 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 30 March 1912		9. AGE (In years last birthday) 54 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CLEVELAND RIDDLE						14. MOTHER'S MAIDEN NAME MARY TAYLOR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT MICHAEL J. PAULINO, 7304 GO. DUCK RD LANHAM, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO (b) Pulmonary Tuberculosis DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)	
20h. (State)		21. I certify that (X) (this hospital) attended the deceased from 1/29/67 to 2/3 , 19 67 , that (X) (we) last saw the deceased alive on 2/3 19 67 , and that death occurred at 2:10 AM from causes and on the date stated above.							
22a. SIGNATURE M.P. Diaz - Giorle M.D.				22b. DATE SIGNED 2-3-67		22c. PHYSICIAN'S NAME (Type) M.P. Diaz-Giorle, M.D.			
22d. ADDRESS Prince Georges General Hospital									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 7 1967		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM		23d. LOCATION (City or Town) ARLINGTON		23e. (County) VA	
24. FUNERAL DIRECTOR W. W. Chambers Co.				ADDRESS RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE FEB 10 1967		25b. REGISTRAR'S SIGNATURE Judge	

02621

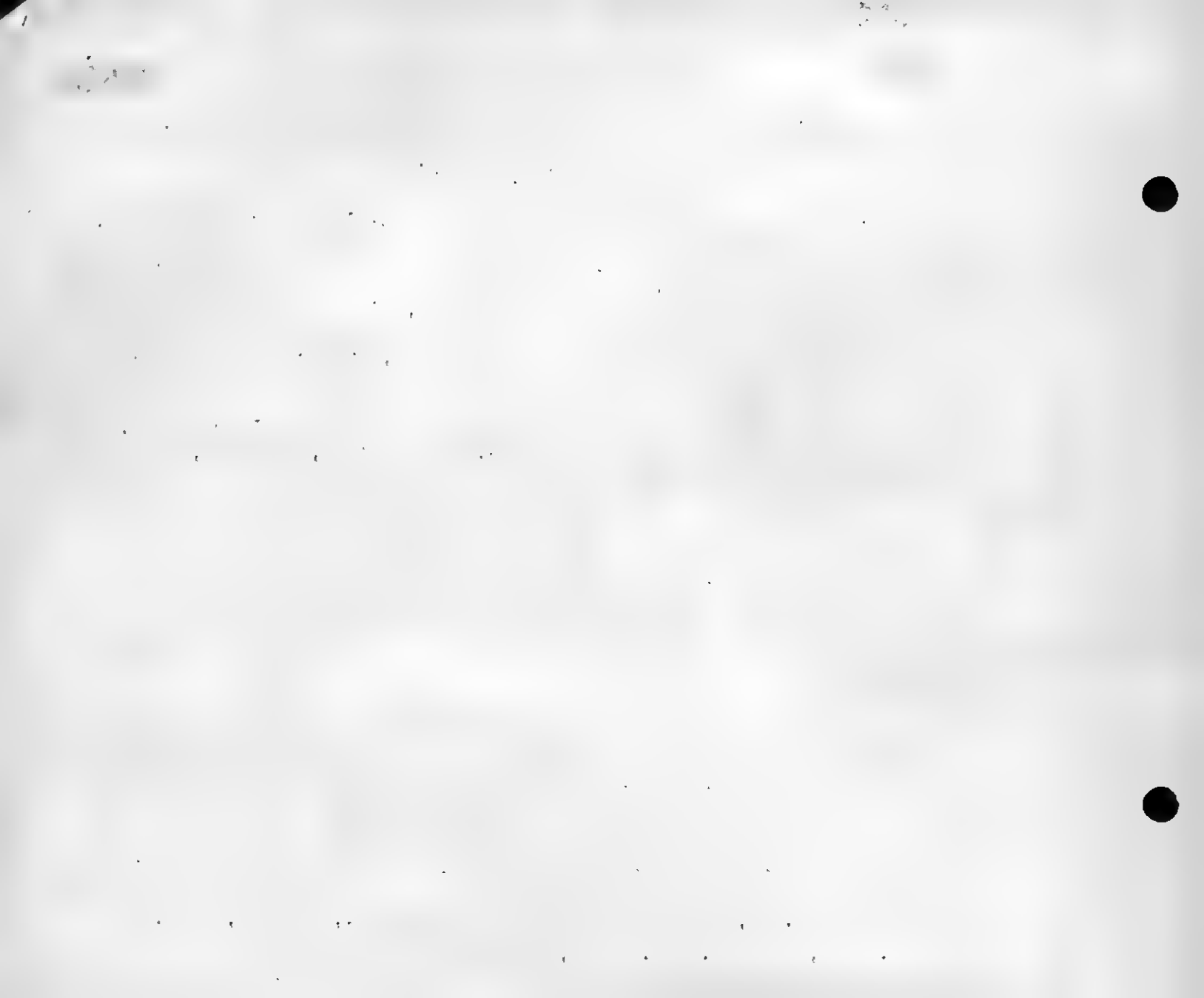
CERTIFICATE OF DEATH

02615

1. PLACE OF DEATH a. COUNTY Prince George's County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 hrs. 34mins. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS Laurel Motel, 605 Washington Blvd e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First Middle Last Rudolph - Pelczar		4. DATE OF DEATH Month Day Year Feb. 14 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1915
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Race track		10b. KIND OF BUSINESS OR INDUSTRY Racing	
11. BIRTHPLACE (County & State, or foreign country) Lawrence, Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Pelczar		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unk		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mrs. Mary Pelczar, Lawrence, Mass		290 Lawrence St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block DUE TO (b) Congestive Heart Failure DUE TO (c) Coronary Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from Feb. 14, 1967 , to Feb. 14, 1967 , that it (we) last saw the deceased alive on Feb. 14, 1967 , and that death occurred at 5:19 M. from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED 2-16-67	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Feb. 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception Cem., Lawrence, Mass.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd. Laurel, Maryland		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 20 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02622

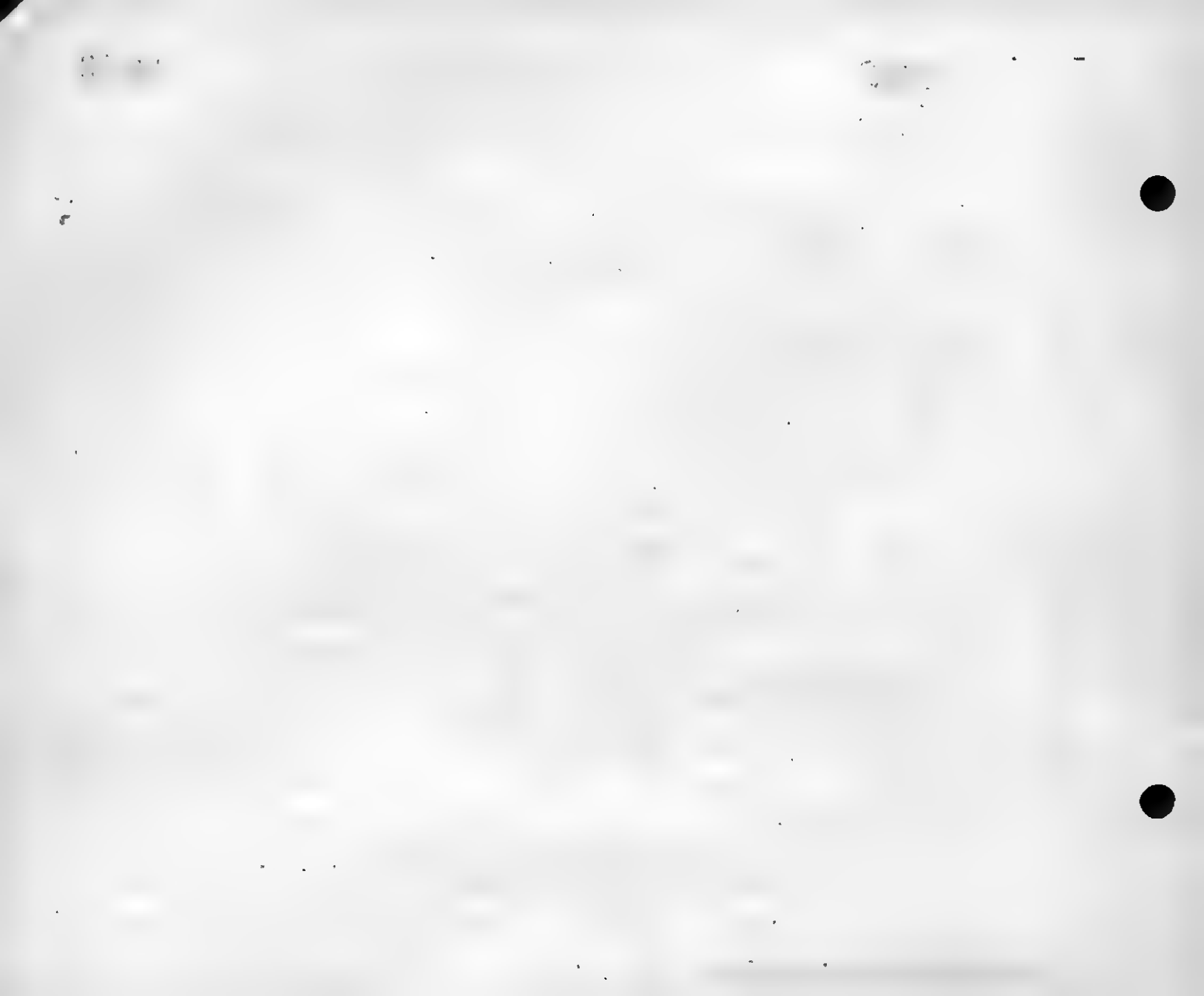
CERTIFICATE OF DEATH

02616

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home Suitland, Md</u>		d. STREET ADDRESS <u>534-13th St., SE 2003</u>	
3 NAME OF DECEASED (Type or print) <u>Lorisa C. Pennington</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>16</u> Year <u>67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <u>Feb 14 1925</u>
9 AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale Nut Products</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Fairfax, Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Miller</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>577091246</u>	
17 INFORMANT <u>Harry Pennington</u>		Address <u>2403 Berkeley St. S.E.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u> </u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/23/67</u> , 19 <u> </u> , to <u>2/16/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/13/67</u> , 19 <u> </u> , and that death occurred at <u>6:50 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Wm. C. Sambert</u>		22b. DATE SIGNED <u>2/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wm. C. Sambert</u>		22d. ADDRESS <u>2432 W St., S.E. 20020</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>	
ADDRESS <u>Simmons Bros. 1661-Good Hope Rd SE Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film 389
6-19-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02617

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY N 16 DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 6874 Riverdale Road, Apt. 242	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Emma Pettengill		4. DATE OF DEATH Month Day Year 2 17 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-15
9. AGE (In years last birthday) yrs. 51		10. USUAL OCCUPATION (Give kind of work done during most of working lifetime) Receptionist	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Lemuel Hicken		14. MOTHER'S MAIDEN NAME Lena ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Phillip Hicken		108 Morse St. Newton, Mass.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Hypertensive coronary arteriosclerotic heart disease DUE TO (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 2-18-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 2/21/67	23c. NAME OF CEMETERY OR CREMATORY Abington Hills	23d. LOCATION (City or town) (County) (State) South Abington Pa
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a. REC'D BY REGISTRAR FEB 23 1967	
		25b. REGISTRAR'S SIGNATURE <i>John Kehoe</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 8-86 2/24/67 mh

02624

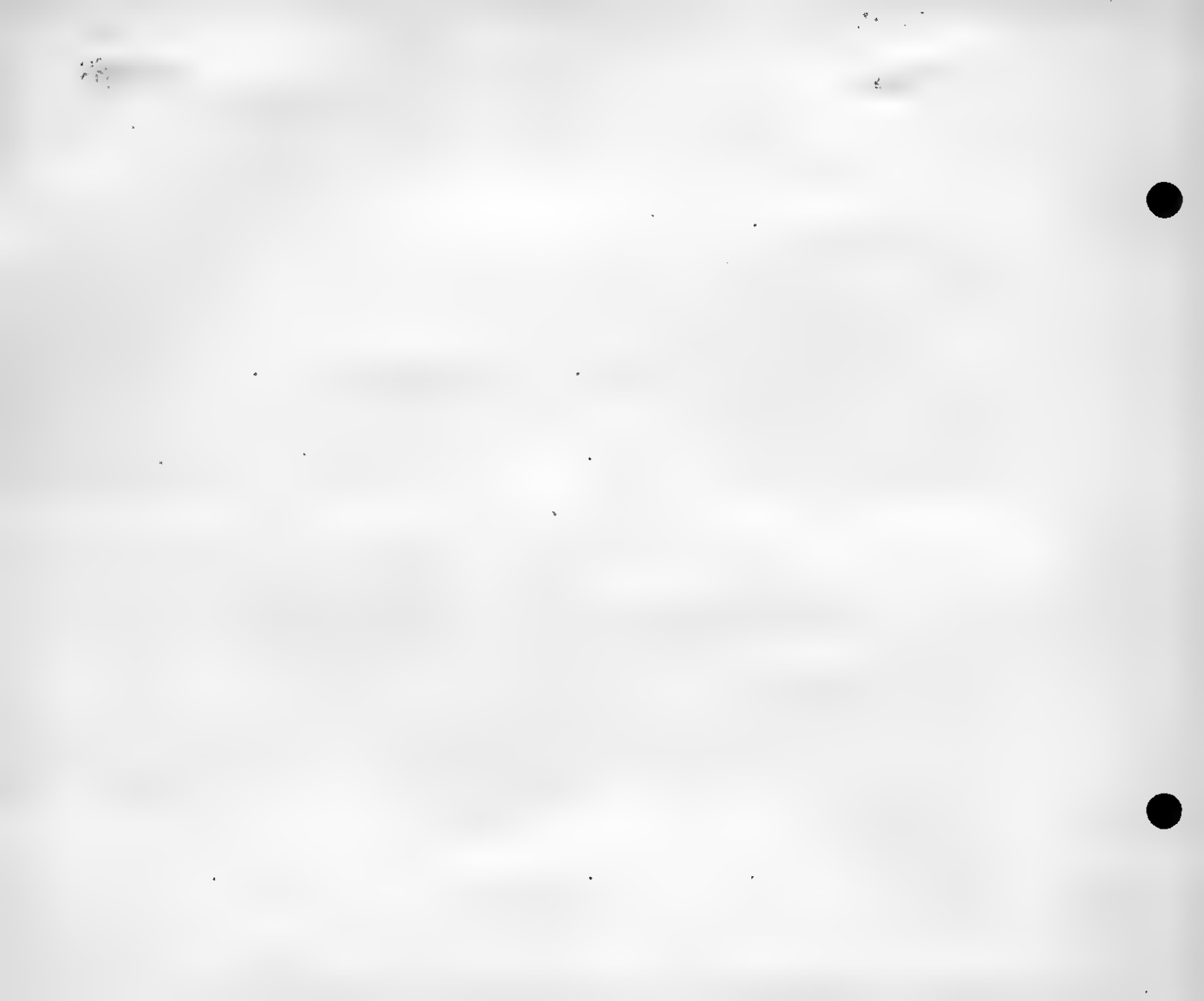
CERTIFICATE OF DEATH

02618

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 4 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, M		d. STREET ADDRESS 3509 Madison Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Louise Middle Helen Last Phipps		4 DATE OF DEATH Month February Day 11 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/10
9 AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator	11. BIRTHPLACE (County & State, or foreign country) Washington D. C.
10b. KIND OF BUSINESS OR INDUSTRY Printing Co.		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert E Dove		14. MOTHER'S MAIDEN NAME Alice E Murdock	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218 32 2274	
17 INFORMANT Alice A Phipps		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 330X IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 4 days work	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 Feb , 19 67 , to 11 Feb , 19 67 , that (I) (we) last saw the deceased alive on 11 Feb , 19 67 , and that death occurred at 1:30 M, from causes and on the date stated above.			
22a. SIGNATURE Robert B. Sasscer		22b. DATE SIGNED 2/11/67	
22c. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.		22d. ADDRESS Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 14, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR P. Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02625

CERTIFICATE OF DEATH

02619

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>			c. LENGTH OF STAY IN 1b <u>4</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suitland Nursing Home</u>				d. STREET ADDRESS <u>4 Panorama Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Sina</u> Middle <u>Mulford</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>19 67</u>			
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 - 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stillwater, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Anzie S. Smith (579 60 5895)</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane McElroy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO XXXXXXXXXX		17. INFORMANT <u>George Price 4 Panorama Dr</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerosis heart disease</u> 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVA. BETWEEN ONSET AND DEATH <u>30 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 26, 1964</u> , to <u>Feb 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 3, 1967</u> , and that death occurred at <u>5:26 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Eugene Yorkoff, M.D.</u>				22b. DATE SIGNED <u>Feb 3, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Eugene Yorkoff, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Silmons Bros.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02626

CERTIFICATE OF DEATH

02620

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3903 - 73rd Avenue		d. STREET ADDRESS 3903 - 73rd Ave.,	
3. NAME OF DECEASED (Type or print) Antonia		4. DATE OF DEATH Month 22 Day February Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Jan. 1912
9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months 1 Days 24 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wadsworth, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Salvatore Puglisi		14. MOTHER'S MAIDEN NAME Angela Gullo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No none		16. SOCIAL SECURITY NO none	
17. INFORMANT Salvatore J. Puglisi		Address 3923 - 12th St., NE DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Cardiac Int. Collaps DUE TO 1912 (b) Arteriosclerosis - 1st degree DUE TO Generalized Atherosclerosis (c) Metastatic Adenocarcinoma of Liver PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH Jul, 24 66 Feb 22 67
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 24, 1967 , to Feb 22, 1967 that (I) (we) last saw the deceased alive on Feb. 22 - 1967 , and that death occurred at 7:55 AM , from causes and on the date stated above.			
22a. SIGNATURE R. H. T. M.D.		22b. DATE SIGNED Feb. 22 - 1967	
22c. PHYSICIAN'S NAME (Type) R. H. T. M.D.		22d. ADDRESS 7200 Northwood Rd E.D. St. Heights	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 25 Feb. 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc. 7400 Ga. Ave., NW		25a. REC'D BY REGISTRAR FEB 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3755 2/14/67 mh

02627

CERTIFICATE OF DEATH

02621

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 6 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 16-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5020 Tuckerman Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Marie Middle C Last Reed		4 DATE OF DEATH Month Feb., Day 3 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Dec., 1892
9. AGE (In years last birthday) 73 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (County & State, or foreign country) Washington D. C.
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry W Sprosser	
14. MOTHER'S MAIDEN NAME Mary A. Maloney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 578 030 187		17. INFORMANT Alton D Reed Address University Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Pontine Hemorrhage (b) Hypertensive Coronary Arteriosclerotic Heart Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 184, 1963, to Feb 3, 1967 that (I) (we) last saw the deceased alive on Feb 3rd 1967, and that death occurred at 5:25 AM from causes and on the date stated above.			
22a. SIGNATURE Till Bergemann		22b. DATE SIGNED Feb 3rd. 1967	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M.D.		22d. ADDRESS Prof. Bldg. Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland Pro Geo (County) Md. (State)
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 7 1967	25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02628

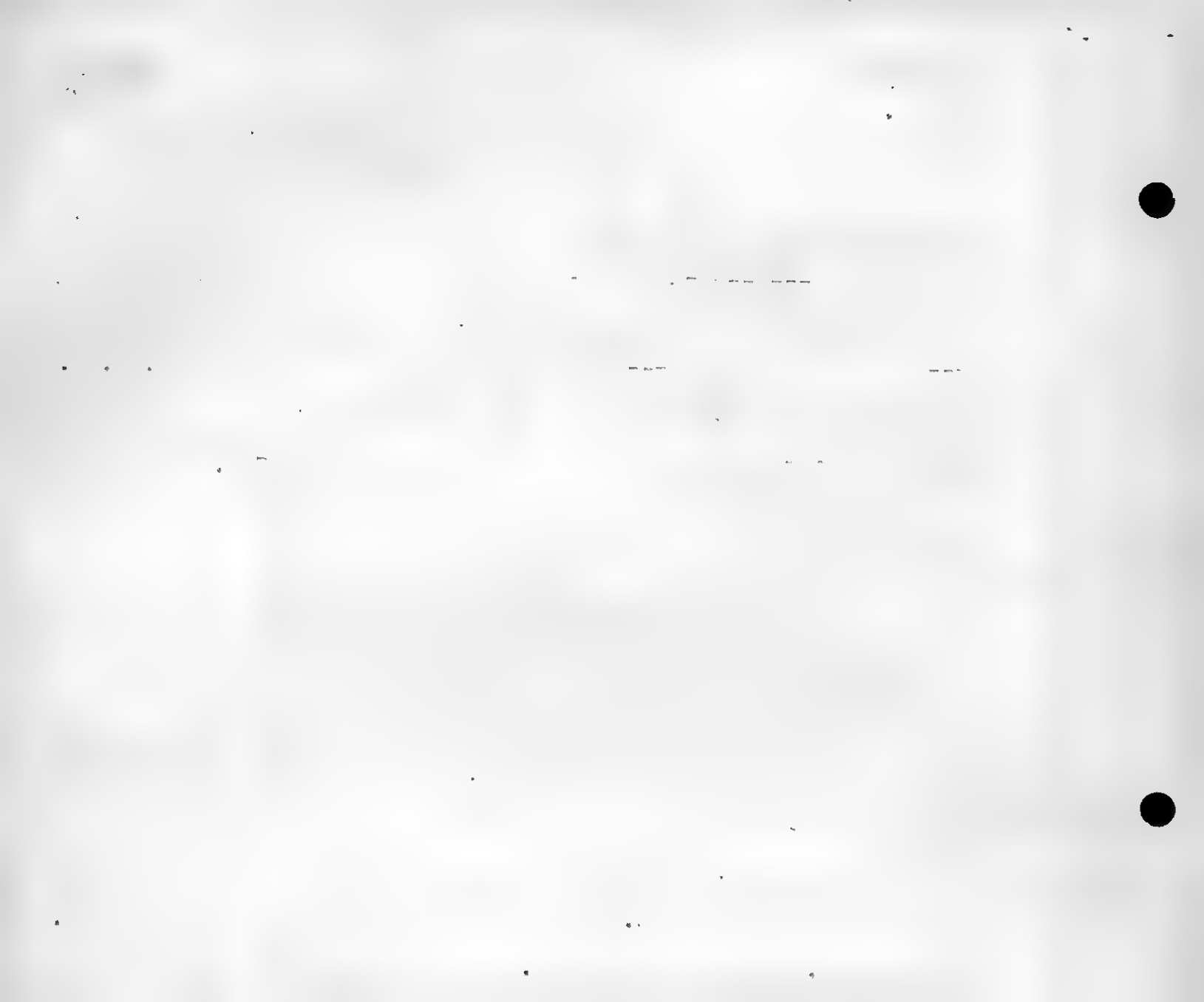
CERTIFICATE OF DEATH

02622

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) Upper Marlboro d. STREET ADDRESS Box 3460 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Tina Marie Richardson Baby Girl Richardson		4. DATE OF DEATH Month Feb. Day 21 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1967
9. AGE (In years last birthday) 8		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marshall Richardson		14. MOTHER'S MAIDEN NAME Mary Windsor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO ---	
17. INFORMANT Marshall Richardson-#2.		18. ADDRESS Same as Item #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3254 IMMEDIATE CAUSE (a) Mongoloid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb. 13, 1967 , to Feb. 21, 1967 , that (I) (we) last saw the deceased alive on Feb. 21, 1967 , and that death occurred at 10 A.M. from causes and on the date stated above			
22a. SIGNATURE Robert B. G. Sasscer		22b. DATE SIGNED FEB. 21, 1967	
22c. PHYSICIAN'S NAME (Type) Robert B. G. Sasscer, M.D.		22d. ADDRESS Box 2150, Upper Marlboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23/67	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City or town) (County) (State) Croom Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



02623

CERTIFICATE OF DEATH

02623

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
3. NAME OF DECEASED (Type or print) First MARIUS Middle J. Last RINAUDOT		d. STREET ADDRESS 6302 Queens Chapel Road	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1886	
9. AGE (In years last birthday) yrs 80		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		11b. KIND OF BUSINESS OR INDUSTRY Restuarant	
11. BIRTHPLACE (County & State, or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jean Bapiste		14. MOTHER'S MAIDEN NAME Catherine (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-03-4968	
17. INFORMANT Daughter		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adeno carcinoma of the Bladder		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Nov , 19 64 , to Feb 13 , 19 67 , that (I) (we) lost saw the deceased alive on February 8, 1967 , and that death occurred at 6: P M, from causes on and on the date stated above.	
22a. SIGNATURE Reuben E. Stone M.D.		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) REUBEN E. STONE		22d. ADDRESS 3417 Minnesota Ave., S.E. Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-67	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02630

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02625

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside d. STREET ADDRESS 210 Woodland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Melanie K Robinson		4. DATE OF DEATH Month 2 Day 23 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-14-1948 9 AGE (In years lost birthday) 19 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11 BIRTHPLACE (State or foreign country) Georgia 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Thomas M. Robinson		14 MOTHER'S MAIDEN NAME Alma J. Smallwood	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Maj. Thomas M. Robinson 17. INFORMANT Address 2327 Duke St. Alexandria, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO Phlebo thrombosis - left internal iliac vein Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)			INTERVAL BETWEEN ONSET AND DEATH minutes days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pregnancy - 6 months			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 2-23-67	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/1967	
23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		23d. LOCATION (City or town) (County) (State) Waldorf, Maryland	
24 FUNERAL DIRECTOR The Demaine Funeral Homes, Inc.		25a. REC'D BY REG. STRAR Charles Judge 25b. REG. STRAR'S SIGNATURE DATE FEB 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02631

CERTIFICATE OF DEATH

02626

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b 3 mo. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.				d. STREET ADDRESS 1908 Florida Avenue, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Gertrude Middle M. Last Rogan				4. DATE OF DEATH Month February Day 11 Year 19 67				
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 26, 1877		
				9 AGE (In years last birthday) yrs. 89		10 IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Seneca Falls, New York		12 CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Rogan				14. MOTHER'S MAIDEN NAME Elizabeth Murphy				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 5 78-64-8287		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Coronary Vasculature</i> DUE TO <i>reflexed stenosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 25 Oct 66 to 10 Feb 67, that (I) (we) last saw the deceased alive on 10 Feb 1967, and that death occurred at 6:47 P.M. from causes and on the date stated above.								
22a. SIGNATURE <i>Robert C. Haile</i>				22b. DATE SIGNED 2/11/67		22c. PHYSICIAN'S NAME (Type) ROBERT C HAILE		
				22d. ADDRESS 35 N.Y. Ave. N.W. WASH. DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-14-67		23c. NAME OF CEMETERY OR CREMATORY ST COLUMBKILL		23d. LOCATION (City or Town) (County) (State) SENECA FALLS, N.Y.		
24. FUNERAL DIRECTOR W.W. CHAMBERS 61400 Chapin St. N.W.				25a. REC'D BY REGISTRAR DATE FEB 15 1967		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02632

02627

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 13 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5967 Rollins Avenue	
3 NAME OF DECEASED (Type or print) Clyde B. Royce		4 DATE OF DEATH Month 2 Day 19 Year 19 67	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-22-06
9. AGE (In years last birthday) yrs 61		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b KIND OF BUSINESS OR INDUSTRY Construction	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Henry Royce		14. MOTHER'S MAIDEN NAME Louise Hershberger	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17 INFORMANT Irma J. Mayhew, 3805 81 Avenue, Forestville		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 5702 IMMEDIATE CAUSE (a) Gangrene of small bowel DUE TO (b) Thrombosis of superior mesenteric vein DUE TO (c) ab. 2 hrs.		INTERVAL BETWEEN ONSET AND DEATH hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Not from causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland M.D.		22. DATE SIGNED 2-19-67	
EXAMINER'S NAME (Type)		Address (Street city town or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/22/67	
23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCAL (City or town) (County) (State) Prince Georges, Maryland	
24 FUNERAL DIRECTOR Wilhelm Funeral Home		ADDRESS 4308 Suitland Road, Suitland, Maryland	
25a REC'D BY REGISTRAR FEB 23 1967		25b REGISTRAR SIGNATURE Chapman	

02633

CERTIFICATE OF DEATH

02628

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 18 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4922 Lasalle Road, Hyattsville, Md.		d. STREET ADDRESS 1516 Chillum Rd. 4922/Lasalle/Road	
3 NAME OF DECEASED (Type or print) M. Virginia		4. DATE OF DEATH Month Feb. Day 27 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1884
9 AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse-Ret. U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11 BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Ryan		14. MOTHER'S MAIDEN NAME Mary E.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO Family Records	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the Cervix with Metastasis DUE TO (b) 171X DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 12 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) person attended the deceased from Feb. 28 , 19 66 , to Feb. 27 , 1967, that (I) person saw the deceased alive on Feb. 25 , 19 67 , and that death occurred at 3:30AM , from causes and on the date stated above			
22a. SIGNATURE Thomas F Collins		22b. DATE SIGNED Feb. 27, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.		22d. ADDRESS 322 H St. N.E. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/2/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

02634

02629

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3815 Oglethorpe St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Ann Taylor Ryder				4. DATE OF DEATH Month Day Year 2 1 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-13	
9. AGE (In years last birthday) 53 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Gardner (Flowers)		10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (County & State, or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Jessie James Jones				14. MOTHER'S MAIDEN NAME Lilly Kitty Mae Pack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 412109345		17. INFORMANT Hospital Records/ Patient/ Husband			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4331 DUE TO Ventricular tachycardia Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-5-63 to 2-1 1967 that (I) (we) last saw the deceased alive on 2-1 1967, and that death occurred at 11:30a M, from the causes and on the date stated above.							
22a. SIGNATURE C. J. Houmann				22b. DATE SIGNED 2-1-67			
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.				22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/67		23c. NAME OF CEMETERY OR Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REGISTRAR DATE 5-20 1967			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02635

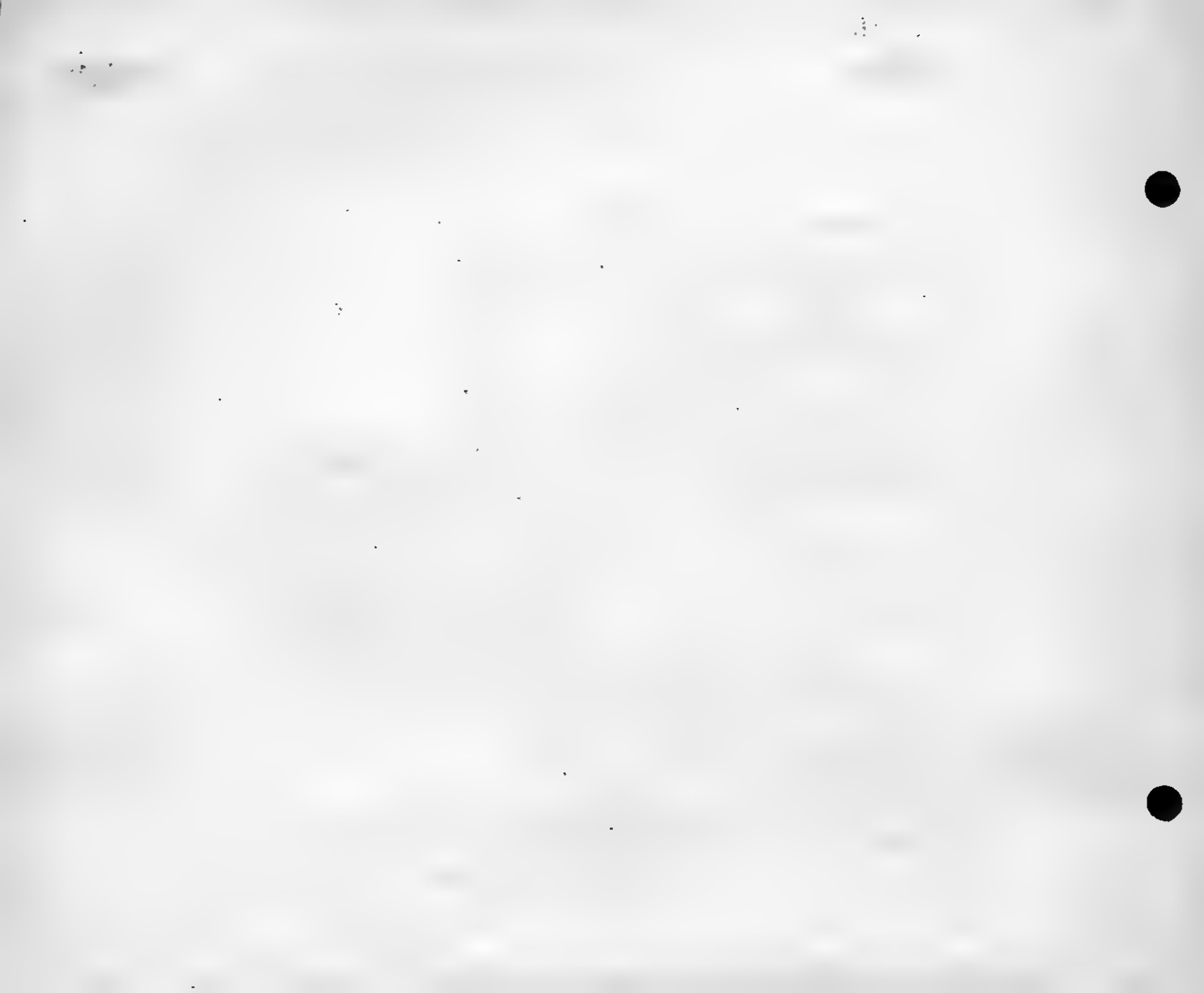
CERTIFICATE OF DEATH

02630

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PR. GEORGE'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b WALDORF	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE VIEW GARDENS		d. STREET ADDRESS RT 2 BOX 130A	
3 NAME OF DECEASED (Type or print) VIOLA FANNY SCHEIBLE		4. DATE OF DEATH Month FEB. Day 6 Year 1967	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	
11 BIRTHPLACE (County & State, or foreign country) D. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL CLARKE		14. MOTHER'S MAIDEN NAME FANNIE CLARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 577-26668	
17 INFORMANT AMY V. SHUGARD		Address WALDORF, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Diabetes Mellitus and DUE TO (c) Arteriosclerosis advanced			INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-21 , 19 67 , to 2-6 , 19 67 , that (I) (we) last saw the deceased alive on Feb 6 , 19 67 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapin M.D.		22b. DATE SIGNED 2/6/67	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, M.D.		22d. ADDRESS CLINTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2-10-67	23c. NAME OF CEMETERY OR CREMATORY FT LINCOLN	23d. LOCATION (City or Town) (County) (State) WASH. D.C.
24. FUNERAL DIRECTOR HUNT FUNERAL HOME WALDORF, MD.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 14 1967	



02636

CERTIFICATE OF DEATH

02631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their office remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released to Dr. Bahrami by Dr. Kehoe (Medical Examiner) for signature.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb Forestville, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Prince George General Hospital		d. STREET ADDRESS 3217--Oak Glen Way S. E.	
3 NAME OF DECEASED (Type or print) EMMA SCHLAEFLI		4. DATE OF DEATH Feb. 20th 19 67	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 26-1890
9 AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Switzerland	
12 CITIZEN OF WHAT COUNTRY? Switzerland		13. FATHER'S NAME Friedrich Gottlieb Schaefli	
14. MOTHER'S MAIDEN NAME Emma Baumgartner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT John Schlaefli- Husband-Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> DUE TO (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u></u>		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arterio-sclerotic heart disease - Heart Failure</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/30, 1963, to 2/2, 1967, that (I) (we) last saw the deceased alive on 2/2, 1967, and that death occurred at 8:42 P.M. from causes and on the date stated above.			
22a. SIGNATURE B. Bahrami		22b. DATE SIGNED Feb. 21-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Bahram Bahrami		22d. ADDRESS 3003-Naylor Rd SE Wash. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros		25a. REC'D BY REGISTRAR DATE FEB 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

02637

CERTIFICATE OF DEATH

02638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal. (If any event, within 72 hours after death.)

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>22 days</u>		d. STREET ADDRESS <u>Rt. 1 Box 295</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>			
3. NAME OF DECEASED (Type or print) <u>Mabel Irene Schultz</u>		4. DATE OF DEATH <u>February 1, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1896</u>
9. AGE (In years birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR IND. STRY <u>Domestic</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>William F. Goddard</u>		14. MOTHER'S MAIDEN NAME <u>Cora Owens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Pine View Gardens Health Care Center</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular disease</u> stating the underlying cause lost. (c) <u>Advanced arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>66</u> to <u>2/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> , 19 <u>67</u> , and that death occurred at <u>9:30 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED <u>Feb. 1st 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred R. Lapin</u>		22d. ADDRESS <u>Clinton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4th 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Simmons Bros 1661 Wood Hope Rd</u>		25a. REC'D BY REGISTRAR <u>Feb 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

02638

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02633

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1HR 35MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS Camp Springs d. STREET ADDRESS 7800 Lanham Lane 203 WOODLAND DRIVE e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH ANNA SCHUMM First Middle Last		4. DATE OF DEATH FEBRUARY 16 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 MAR 1894 9. AGE (In years last birthday) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Kreis Frankenberg GERMANY - ERNFT
13. FATHER'S NAME Heinrich Schneider (UNKNOWN) / SCHNIEDER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT HELEN DOUGLASS-DAUGHTER-SAME AS #2		14. MOTHER'S MAIDEN NAME GERTRUDE (UNKNOWN) Trusheim	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR FAILURE DUE TO (b) CERBRAL VASCULAR ACCIDENT DUE TO (c) 2 HOURS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 16 FEB , 19 67 to 16 FEB , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 16 FEB , 19 67 , and that death occurred at 5:30 M. from causes and on the date stated above.			
22a. SIGNATURE <i>John Bristow M.D.</i>		22b. DATE SIGNED 16 FEB 1967	
22c. PHYSICIAN'S NAME (Type) JOHN W BRISTOW, CAPT, USAF, MC ANDREWS AFB, WASHINGTON DC 20331		22d. ADDRESS USAF HOSPITAL ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/20/1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Hall	23d. LOCATION (City or Town) (County) (State) Fort Belvoir, Va
24. FUNERAL DIRECTOR <i>John A. Hittingly</i>		25a. REC'D BY REGISTRAR 131-11-25412	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

24

25



26



02639

CERTIFICATE OF DEATH

02634

1 PLACE OF DEATH a. COUNTY Prince Geo.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN b 3 wks. 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home				d. STREET ADDRESS 3001 - Taylor St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Anna M. Seymore		4 DATE OF DEATH Feb. 16 19 67		5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH 7/22/1893		9. AGE (In years last birthday) 73 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Rhode Island	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Harris		14. MOTHER'S MAIDEN NAME Emma Plante		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Geo. W. Seymore, Jr. (above address)		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>Carcinomatosis (generalized)</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 years</u> <u>5 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from <u>1936</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/16/67</u> 19 <u>67</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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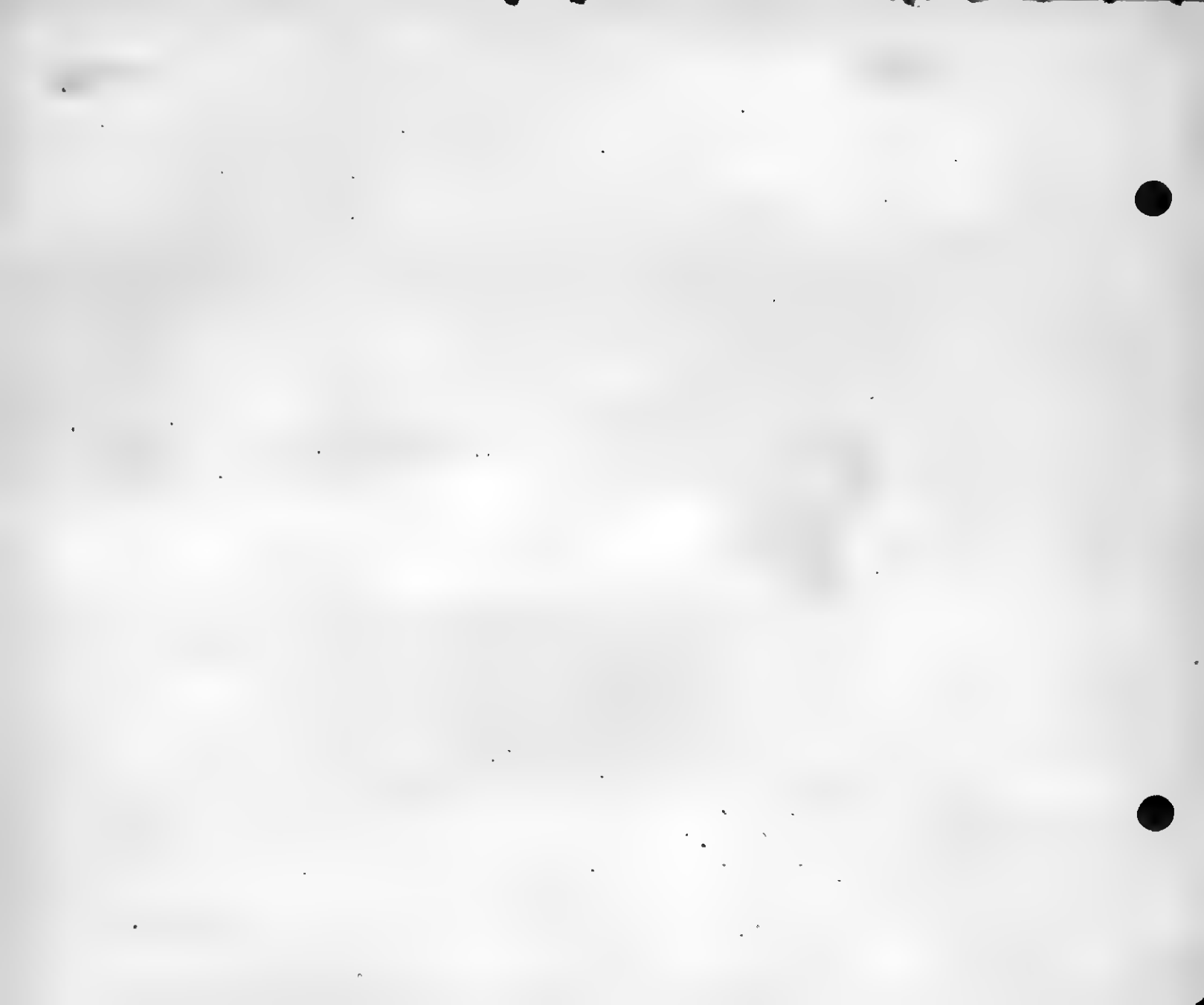
17



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>02640</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02635</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>						c. LENGTH OF STAY IN b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>18 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5504 Sargent Road</u>						d. STREET ADDRESS <u>5504 Sargent Road</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALVATORE (nun) SGRO</u>						4. DATE OF DEATH Month Day Year <u>Febr 10 1967</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TILESETER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>TILE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Antonio Sgro</u>						14. MOTHER'S MAIDEN NAME <u>Josephine ARENA</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>None</u>						16. SOCIAL SECURITY NO. <u>578010700</u>		17. INFORMANT <u>Lena Sgro</u> Address <u>5504 Sargent Rd. West Hyattsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). I											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1966</u> to <u>Feb 10</u> , 1967, that (I) (we) last saw the deceased alive on <u>Feb 9</u> , 1967, and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Harry N. Carlton</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 10, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>						22d. ADDRESS <u>8811 Colebrook Rd, Silver Spring</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb 15, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>		
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>						ADDRESS <u>8434 Ga. Avenue</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Harold S. Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

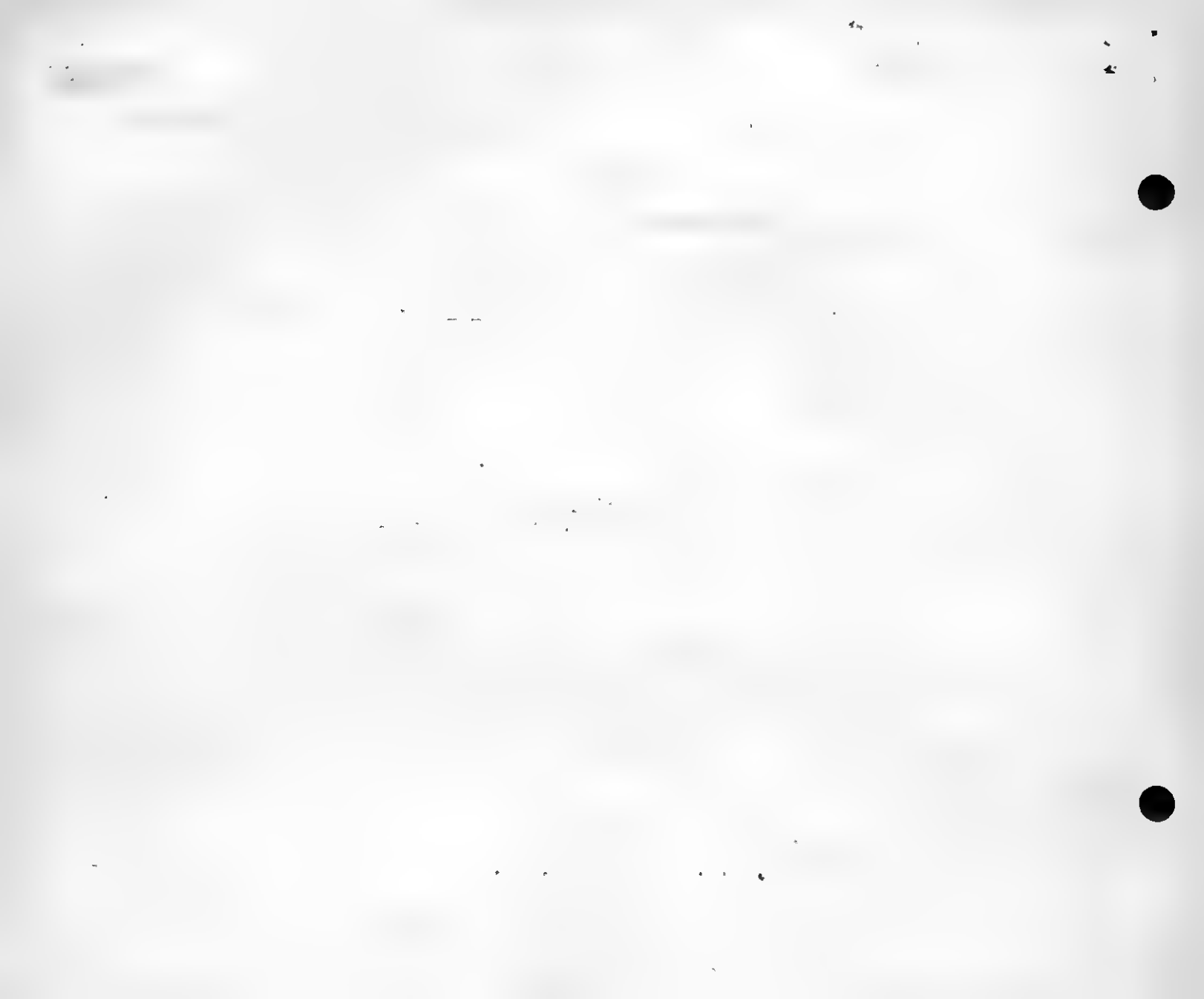
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02636

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if not in residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Benjamin Shevitz		4 DATE OF DEATH Month 2 Day 22 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-1-1908
9 AGE (In years lost birthday) 63 yrs.		10 IF UNDER 1 YEAR Months 63 Days 22 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11 BIRTHPLACE (State or foreign country) Lithuania		12 CITIZEN OF WHAT COUNTRY? ?	
13 FATHER'S NAME Philip Shevitz		14 MOTHER'S MAIDEN NAME Vetta ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. UNKNOWN	
17 INFORMANT Mrs. Jean Shevitz, 3411 Kimble Road #7		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 2-23-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURLIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/67	
23c. NAME OF CEMETERY OR CREMATORY Anshe Emunah-Aitz Chaim		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Sal Levinson		25. RECEIVED BY REGISTRAR Brook F.H.	
25b. REGISTRAR'S SIGNATURE Brook F.H.		DATE FEB 27 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02642

CERTIFICATE OF DEATH

02637

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN 1b 6 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e STREET ADDRESS 3707 Campus Drive	
3 NAME OF DECEASED (Type or print) First Middle Last William Grover Shipley		4 DATE OF DEATH Month Day Year February 19 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-14-1884
9 AGE (In years last birthday) 82 yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY U. of Md.	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CIT ZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Lemuel Shipley		14 MOTHER'S MAIDEN NAME Annie Phelps	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown none		16 SOCIAL SECURITY NO	
17 INFORMANT Address Medical Record/brother-in-law			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Right c DUE TO Left Hemisphere (b) Hypertensive cerebrovascular disease (c) 10 yrs + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 6 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/12, 1967 to 2/19, 1967, that (I) (we) lost soul the deceased alive on 2/19/67, and that death occurred at 1:30 M, from causes and on the date stated above.			
22a SIGNATURE W. L. Etienne		22b. DATE SIGNED 2/19/67	
22c PHYSICIAN'S NAME (Type) W. L. Etienne, M.D.		22d ADDRESS 4713 Berwyn Rd., College Park, Md.	
23a BURIAL, CREMATION, REBURY (Specify) Burial	23b DATE THEREOF 2/22/67	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24 FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.		25a. RECD BY REGISTRAR DATE FEB 23 1967	25b REGISTRAR'S SIGNATURE



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02643

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02638

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS Rt. 2 Box 151 Wash. Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Albert Shorter				4. DATE OF DEATH Month Day Year February 3 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1906 60	
9. AGE (In years last birthday) yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto		9. AGE (In years last birthday) yrs	
11. BIRTHPLACE (State or foreign country) Tenn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William M. Shorter				14. MOTHER'S MAIDEN NAME Anna Rader			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address George Smith 1325 Maple Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour am pm 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address Riverdale, Md		22. DATE SIGNED 2-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		23d. LOCATION (City or Town) (County) (State) Poores, Maryland	
24. FUNERAL DIRECTOR Amberline 1328 Sulphur Sp. Rd.				25a. REC'D BY REGISTRAR DATE 2 6 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jago	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02644

CERTIFICATE OF DEATH

02639

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS Route #1, Box 203-Hillmeade	
3. NAME OF DECEASED (Type or print) William Shrewsbury, Middle James Shrewsbury, Last William		4. DATE OF DEATH Month Feb. Day 26, Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/16
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assessor		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Commission	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeremiah Chas. McCauley Shrewsbury		14. MOTHER'S MAIDEN NAME Martha Pinchbeck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) (If yes give war or dates of service) W.W.II		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Emily Shrewsbury- #2		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 DUE TO Congestive Heart Failure (b) Anteriosclerotic Heart Disease (c) 5 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June, 1967, to 2/26, 1967, that (I) (we) last saw the deceased alive on 2/26, 1967, and that death occurred at 10:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE Norman D. Comeau		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) Norman D. Comeau, M.D.		22d. ADDRESS 3503 Pennys Mt Rd, Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/1/67	23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	23d. LOCATION (City or town) (County) (State) Upper Marlboro Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE MAR 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02645

CERTIFICATE OF DEATH

02640

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, D. C. b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN IB 9 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital			d. STREET ADDRESS 735 N. J. Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Eugene Sills			4. DATE OF DEATH Month February Day 6 Year 1967		
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/00		9. AGE (In years last birthday) 67 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (County & State, or foreign country) Fla.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Saul Sills			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	17. INFORMANT decendent		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Status postoperative sigmoid colostomy DUE TO (b) Necrosis and gangrene of sigmoid colon DUE TO (c) Left renal abscess with perirenal infection and adhesions					INTERVAL BETWEEN ONSET AND DEATH 23 days 24 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/13/1966 to 2/6/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/6/1967 , and that death occurred at 8:00AM from causes and on the date stated above.					
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/6/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/11/67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL HOME Stewart Funeral Home		25a. REC'D BY REGISTRAR John T. Stewart		25b. REGISTRAR'S SIGNATURE Charles Judge	
4001 Benning Rd.,		DATE FEB 10 1967			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02646

02641

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro c. LENGTH OF STAY IN b 25 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 3130		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro d. STREET ADDRESS Box 3130	
3. NAME OF DECEASED (Type or print) Raymond Cleveland Skillman		4. DATE OF DEATH Month Day Year February 7, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1892
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		9b. KIND OF BUSINESS OR INDUSTRY Own Farm	9. AGE (In years last birthday) 74 yrs.
10a. FATHER'S NAME Charles William Skillman		10b. MOTHER'S MAIDEN NAME Annie Virginia Newton	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 5/26/18-5/24/19		12. SOCIAL SECURITY NO. Ruby Josephine Skillman-#2	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 443A Septicemia Conditions, if any, which gave rise to immediate cause (b) Pneumonia (a), stating the underlying cause last. DUE TO (c)		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
15a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		15b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
16a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	16b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	16c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	16d. (City or town) (County) (State)
17. I certify that (I) (this hospital) attended the deceased from Mar 19 62 to Feb 19 67 , that (I) (we) last saw the deceased alive on 2/1/19 67 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
18a. SIGNATURE A. Clark Holmes 22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M. D.		18b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Upper Marlboro, Maryland 20870	
19a. BURIAL, CREMATION, REMOVAL (Specify) Burial	19b. DATE THEREOF 2/10/67	19c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens	19d. LOCATION (City, town or county) (State) Waldorf, Maryland
20. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		21. REC'D BY REGISTRAR FEB 14 1967	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02647

CERTIFICATE OF DEATH

02642

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 5023 Geronimo St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thais B. Smith						4. DATE OF DEATH Month Day Year 2-17-1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-08		9. AGE (In years past birthday) 58 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Bennett				14. MOTHER'S MAIDEN NAME Catherine Cassidy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Medical Record/spouse			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conjunctive Heart Failure</i> DUE TO <i>Stenosis of Pulmonary artery</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>Conjunctive Heart Disease</i> (c)				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 13, 1967</i> to <i>Feb 17, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb 17, 1967</i> , and that death occurred at <i>10:30</i> A.M. from causes on and on the date stated above.									
22a. SIGNATURE <i>L W Malin</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <i>2-17-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>L W Malin MD</i>				22d. ADDRESS <i>Riverdale, Md</i>					
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 21, 1967		23c. NAME OF CEMETERY OR CREMATORY St Joseph's catholic		23d. LOCATION (City or town) (County) (State) Dodgeville Wisconsin			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE <i>FEB 23 1967</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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21

02648

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02643

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				e. STREET ADDRESS 4811 Navahoe Street			
3. NAME OF DECEASED (Type or print) First Middle Last William M Smith				4. DATE OF DEATH Month Day Year Feb. 26, 1967			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1918	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Marion N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Potts				14. MOTHER'S MAIDEN NAME Nellie McFerran			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Phyllis Smith Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Hypertensive cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Six days several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 1/14, 1967, to 2/26, 1967, that (if we) last saw the deceased alive on 2/26, 1967, and that death occurred at 4:52 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick H. Wilhelm				22b. DATE SIGNED 2/26/67		22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-2-67				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Queens Chapel	
23d. LOCATION (city, town or county) Mount Airy Md				23e. LOCATION (city, town or county) (State)			
24. FUNERAL DIRECTOR H S Washington 4925 Deane Avenue				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02643

CERTIFICATE OF DEATH

02644

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE Maryland c. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4306 Claggett Road	
3 NAME OF DECEASED (Type or print) First Middle Last Emma Agnes Sommers		4 DATE OF DEATH Month Day Year February 7, 1967	
5. SEX Female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-7-96
9 AGE (In years last birthday) 70 yrs.		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward Devereaux	
14. MOTHER'S MAIDEN NAME Ella Cooney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Daughter/Medical Record	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN. ARTERIOSCLEROSIS (c)			
INTERVAL BETWEEN ONSET AND DEATH ONE DAY UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-6, 1967, to 2-7, 1967, that (I) (we) last saw the deceased alive on 7 FEB. 1967, and that death occurred at 12:10 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 2-7-67	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.		22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF 2/11/67	23c. NAME OF CEMETERY OR CREMATOR Felix Catholic Church	23d. LOCATION (City or Town) (County) (State) Clifton Springs N. Y.
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 10 1967	
		25b. REGISTRAR'S SIGNATURE William J. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

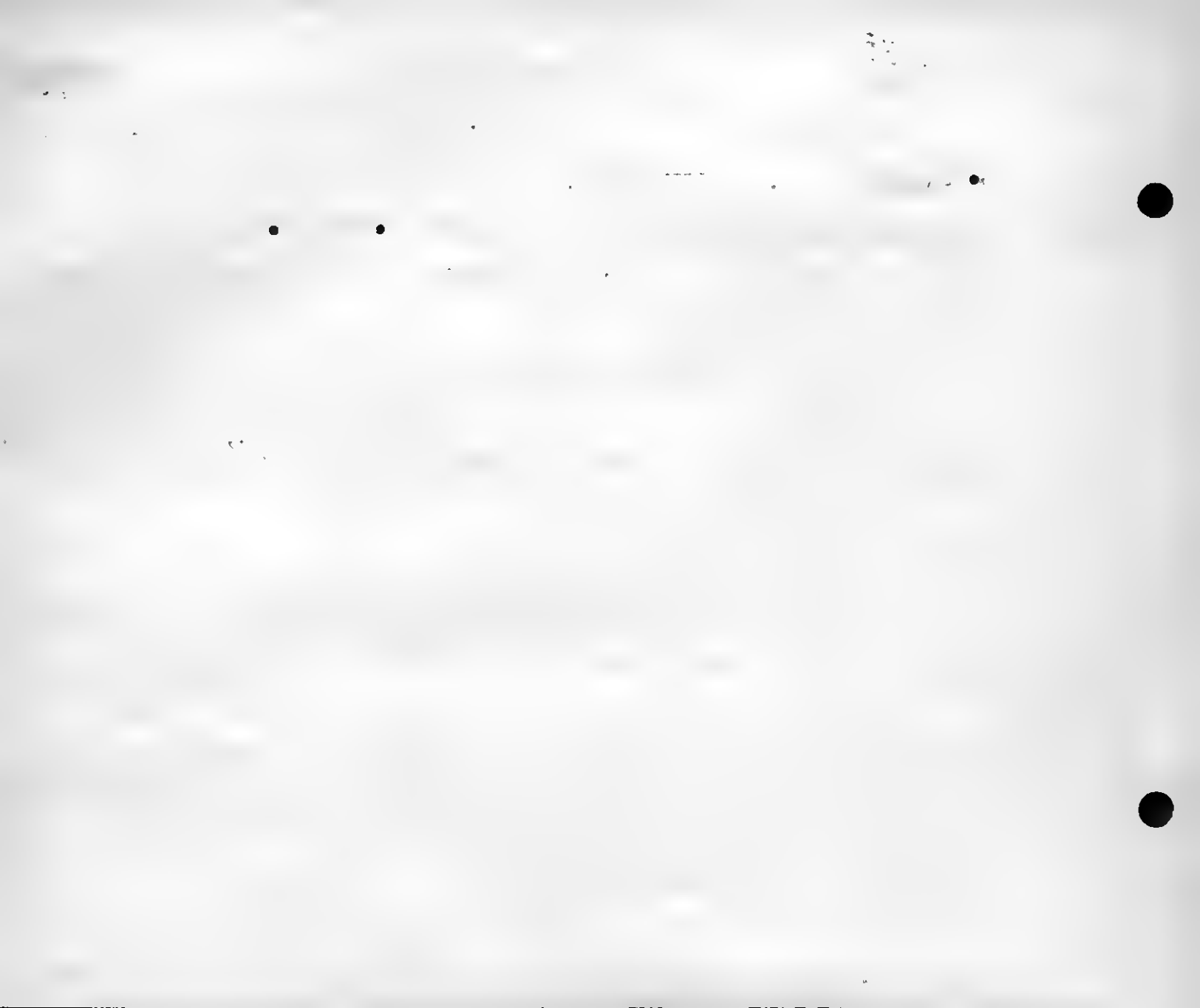
02650

02645

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md. c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md. d. STREET ADDRESS 7204 Bowdoin avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alma M. Speaks		4. DATE OF DEATH Month February Day 20 Year 1967	
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Runs Boarding House		11. BIRTHPLACE (County & State, or foreign country) Kentucky	
13. FATHER'S NAME Silas F. Wright		14. MOTHER'S MAIDEN NAME Rhoda Caldwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Relatives & Son (Earnest Speaks)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO (b) MYOCARDIAL INFARCTION DUE TO (c) 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-17 , 19 67 , to 2-20 , 19 67 , that (I) (we) last saw the deceased alive on 2-20 , 19 67 , and that death occurred at 12:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 2-20-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Englewood Cemetery	23d. LOCATION (City or Town) (County) (State) Ilazard Kentucky
24. FUNERAL DIRECTOR F Gasch's Sons		25a. REC'D BY REGISTRAR DATE FEB 24 1967	
ADDRESS Hyattsville Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02651

02646

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGE'S</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVERLY</i>		c. LENGTH OF STAY IN 1b <i>161</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>PRINCE GEORGE'S GENERAL HOSP.</i>		d. STREET ADDRESS <i>4104 MADISON ST.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ANNA M. STEVENS</i>		4. DATE OF DEATH Month Day Year <i>FEB. 4 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-10</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE (in years last birthday) yrs. <i>57</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Bernard J Gallagher</i>		14. MOTHER'S MAIDEN NAME <i>Alice Bell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William V Stevens</i>		Address <i>Hyattsville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>LARGE MOUTH OF Bacteria & Generalized</i> <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Myocardial Infarction to Lungs, Lungs & Spleen</i> (c) <i>Obesity & Abdomen (Liver)</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1-31</i> , 19 <i>67</i> , to <i>2-4</i> , 19 <i>67</i> ; that (I) (we) last saw the deceased alive on <i>2-4</i> , 19 <i>67</i> , and that death occurred at <i>2:50</i> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>A. Deitz</i>		22b. DATE SIGNED <i>2-5-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A Deitz</i>		22d. ADDRESS <i>Hyattsville, Maryland.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Feb 8, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>Hyattsville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>FEB 8 1967</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02652

Items # 8 & 9 info taken from birth cert
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02647

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e STREET ADDRESS 7250 Glen Ridge Drive			
3 NAME OF DECEASED (Type or print) Albert Hunter Stickell				4 DATE OF DEATH Month 2 Day 11 Year 19 67			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Jan. 17 June 1932	
9 AGE (In years past birthday) 34 35 yrs		F UNDER 1 YEAR Months Days Hours Min		F UNDER 24 HRS Months Days Hours Min		12 CITIZEN OF WHAT COUNTRY? U S A	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b KIND OF BUSINESS OR INDUSTRY Construction			
11 BIRTHPLACE (State or foreign country) Pro Geo Md				12 MOTHER'S MAIDEN NAME Alice E Winslow			
13 FATHER'S NAME Joseph Lester Stickell				14 MOTHER'S MAIDEN NAME Alice E Winslow			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no				16 SOCIAL SECURITY NO 212 28 8226			
17 INFORMANT Betty L Stickell				Address Hyattsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Coronary artery occlusion, right and left coronary arteries. (b) Coronary arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i>				22. DATE SIGNED 2-13-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb 15, 1967		23c NAME OF CEMETERY OR CREMATORY Pt Lincoln Cemetery		23d LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a REC'D BY REGISTRAR DATE FEB 16 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

02653

CERTIFICATE OF DEATH

02648

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>6835 Riverdale Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Franciscus</u> Middle <u>G.</u> Last <u>STOLP</u>		4 DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 28, 1915</u>
9 AGE (In years last birthday) <u>52</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11 BIRTHPLACE (Country & State or foreign country) <u>Castleton, N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franciscus Stolp</u>		14. MOTHER'S MAIDEN NAME <u>Whilmenia Vanderhorst</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>111 01 6417</u>	
17. INFORMANT <u>Jean Stolp</u>		Address <u>Same as #2 (wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> 4201 DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infarcts of spleen, kidneys & liver</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Home</u>
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> , 19 <u>67</u> , to <u>Feb. 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 11</u> , 19 <u>67</u> , and that death occurred at <u>7:40 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Peter Duus</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Peter Duus</u>		22d. ADDRESS <u>Capital Heights, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>	23d. LOCATION (City or Town) (County) (State) <u>Castleton Rensselaer N.Y.</u>
24 FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a REC'D BY REGISTRAR <u>Hyattsville, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>J. C. ...</u>		DATE <u>FEB 16 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

02652

23a BURIAL, CR
REMOVAL
Burial

23b DATE THEREOF
2/17/67

23c. NAME OF CEMETERY OR CREMATORY
Lisle Cemetery

23d. LOCATION (City or Town) (County) (State)
 Lisle New York

24. FUNERAL DIRECTOR

ADDRESS



25a REC'D BY REGISTRAR

25b REGISTRANT'S SIGNATURE *[Signature]*

Ritella K. 4. 10/44

der Hauptstadt.

DATE MAR 1

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02649

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b DOA			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade				d. STREET ADDRESS 1st. US Army Medical Lab.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harriett JEAN Terry				4. DATE OF DEATH Month 2 Day 20 Year 1967			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-30-1941	
9. AGE (In years past birthday) 25 yrs		10. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) MASON TOWN, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife				10b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13. FATHER'S NAME GEORGE TERRY				14. MOTHER'S MAIDEN NAME EVA ELLIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES				16. SOCIAL SECURITY NO 162-34-7255		17. INFORMANT U.S. Army Records, Ft. Meade	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Driver of car involved in collision			
20c. TIME OF INJURY Month, Day, Year Hour: 9:49pm Month: 2-20- Year: 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 1, Laurel, Maryland				20f. (City or town) (County) / (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 2-21-67			
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or DISPOSAL (Specify) BURIAL		23b. DATE OF REPOSS FEB 25 67		23c. NAME OF EMBLERY OR CREMATORY CHURCH HILL CEM.		23d. LOCATION (City or town) (County) (State) McEllenstown PA.	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Md.				25a. REC'D BY REGISTRAR FEB 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film 3-85 2/14/67 ml

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02656

02650

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN IS DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Maryland Medical Center			d. STREET ADDRESS 9711 Wymann Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Keefe Linwood Thompson			4. DATE OF DEATH Month 2 Day 3 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1888		9. AGE (In years last birthday) 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Festes Mosby Thompson			14. MOTHER'S MAIDEN NAME Martha E Griffith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO 705 10 2020		17. INFORMANT Margarite Thompson Address Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Phlebo-thrombosis, lower extremities (c) Coronary arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH minutes unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Noted causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 2-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 6, 1967		23c. NAME OF CEMETERY OR REPOSITORY Ft Lincoln Cemetery	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 8 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

02657

CERTIFICATE OF DEATH

02651

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's General	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5016 Sheridan St.	
3 NAME OF DECEASED (Type or print) Walter J. Tobin		4 DATE OF DEATH Month Feb. Day 15 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/9/04
9. AGE (n years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work months, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory	
11 BIRTHPLACE (County & State or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Tobin Sr.		14. MOTHER'S MAIDEN NAME Annie Crown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 577 03 8312	
17. INFORMANT Emily E. Tobin Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) Obduction (R) coronary artery DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , to 2/14 , 1967, that (I) (we) last saw the deceased alive on 2/14 , 1967, and that death occurred at 12 A.M. from causes and on the date stated above.			
22a. SIGNATURE Leon R. Levitsky		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.		22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF 2/18/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

800

800



(2)



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

AP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02653

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS 3612 39th Avenue	
3. NAME OF DECEASED (Type or print) John Nelson Torvestad		4. DATE OF DEATH Month February Day 6 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1891
9. AGE (In years last birthday) 75 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney at law	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ole Torvestad		14. MOTHER'S MAIDEN NAME Hanna Lensigraf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 215 36 4134	
17. INFORMANT John A. Torvestad		12902 Bentley Lane Bowie, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 6 mos		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 2-7-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/9/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR FEB 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #0387 3/22/67 DC

CERTIFICATE OF DEATH

02659		02654	
1 PLACE OF DEATH a. COUNTY CLINTON Pr. George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict MD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Md Hosp.		d. STREET ADDRESS 1101	
3 NAME OF DECEASED (Type or print) EMMA B. TOLIVER		4 DATE OF DEATH Month 2 Day 17 Year 1967	
5 SEX Female	6 COLOR OR RACE negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-13-81
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		9b. KIND OF BUSINESS OR INDUSTRY Gainsville, Va	9c. AGE (in years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Gainsville, Va	10c. CITIZEN OF WHAT COUNTRY? US
11 BIRTHPLACE (County & State or foreign country) Gainsville, Va		12 CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Cornelius Blockburn		14. MOTHER'S MAIDEN NAME Martha Churchman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Catherine Coy		Address 6196 Springdale Rd DE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL THROMBI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastatic CARCINOMATOSIS (c) Ca of the Lung		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) PROGRESSIVE CAQUEXIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-11 , 19 67 , to 2-17 , 19 67 , that (I) (we) last saw the deceased alive, on 2-17 , 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapin		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN		22d. ADDRESS 5011 Mid Hosp Clinton, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 2-23-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat		23d. LOCATION (City or town) (County) (State) Arlington Va	
24. FUNERAL DIRECTOR Hagins 389-BI. aumn. Wash. DC.		25a. REC'D BY REGISTRAR DATE FEB 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02660

CERTIFICATE OF DEATH

02655

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Lane</u>		d. STREET ADDRESS <u>Cherry Lane</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Tucker</u> Middle <u>Tucker</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. CO. OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1884</u> 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clothing store</u>	9. AGE (In years last birthday) <u>82</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Laurel Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Norman Tucker, Laurel Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4221 A-S-C - V.D. - Failure</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>1/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/31/67</u> , 19 <u>67</u> , and that death occurred at <u>1 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J M Warren</u>		22b. DATE SIGNED <u>2/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J M Warren</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Hill Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Md</u>
24. FUNERAL DIRECTOR <u>McWitt Danielson, Laurel Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

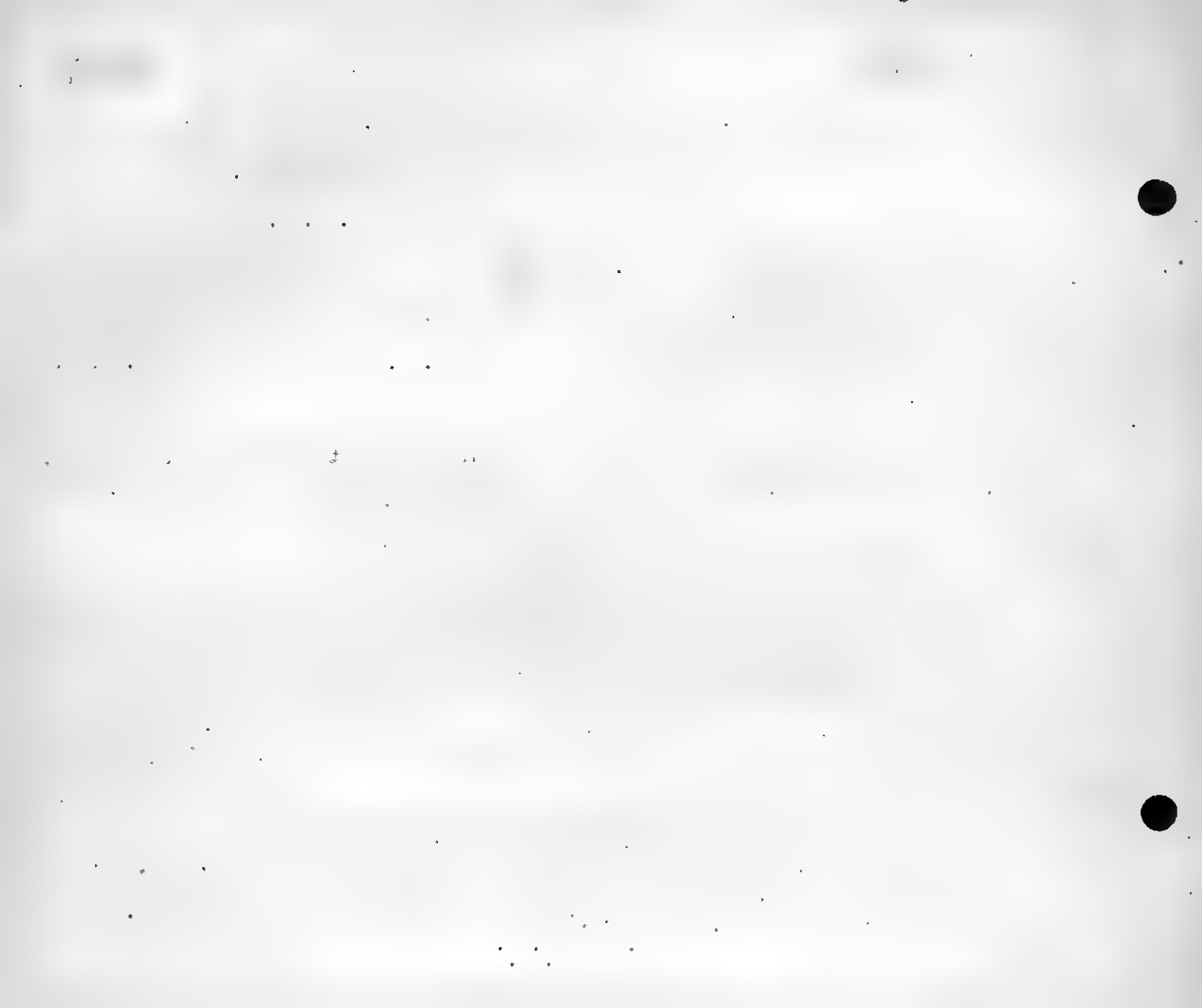


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02661 CERTIFICATE OF DEATH 02656

1. PLACE OF DEATH Prince George's a. COUNTY Beaver Hgts. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 4 years		d. STREET ADDRESS Beaver Hgts.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lottie B. Wagstaff		4. DATE OF DEATH Month 2 Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/10/1888
9. AGE (In years last birthday) 78 yrs.		10. BIRTHPLACE (County & State, or foreign country) N. C.	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Cupid Hooper		14. MOTHER'S MAIDEN NAME Sallie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Carlton Wagstaff		Address 1427 Maryland Ave. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO (b) Atherosclerosis DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 19 66 to January 31 19 67, that (I) (we) last saw the deceased alive on January 31 19 67, and that death occurred at 5:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE Theresa O. Berry		22b. DATE SIGNED February 16, '67	
22c. PHYSICIAN'S NAME (Type) Theresa V. Berry, MD		22d. ADDRESS 24 Florida Ave. N.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/19/67	
23c. NAME OF CEMETERY OR CREMATORY Oakhill Cemetery		23d. LOCATION (City, town or county) (State) Danville Va.	
24. FUNERAL DIRECTOR Low Funeral Home		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 1425 Md. Ave. N. E. D. C.		DATE FEB 20 1967 Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02662

CERTIFICATE OF DEATH

02657

1. PLACE OF DEATH a. COUNTY P.G. County Riverdale, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Hyattsville, Md. b. COUNTY P.G. County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Ieland Hospital		e. STREET ADDRESS 5103 43rd Ave.	
3. NAME OF DECEASED (Type or print) First Emily Middle A Last Watson		4. DATE OF DEATH Month February Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-90
9. AGE (In years last birthday) 76 yrs		10. FUND 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None CLERK		10b. KIND OF BUSINESS OR INDUSTRY COUNTY OFFICE	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GLADMON		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Eugene Ieland Hospital, 4408 Queensbury Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN. ARTERIOSCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ONE WEEK UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 7 FEB , 19 67 , to 13 FEB , 19 67 , that (I) (we) last saw the deceased alive on 13 FEB , 19 67 , and that death occurred at 6:15 P.M. from causes and on the date stated above.	
22a. SIGNATURE C.J. HOUHANN		22b. DATE SIGNED 2-13-67	
22c. PHYSICIAN'S NAME (Type) C.J. HOUHANN		22d. ADDRESS RIVERDALE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 16 FEB 1967	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE FEB 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23 a,b,c and Film #6325 2/27/67 pc

Item #3 Film #3305 3/10/67 pc

02663

CERTIFICATE OF DEATH

02658

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Tuxedo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5811 Arbor Street	
3 NAME OF DECEASED (Type or print) ETHEL		4 DATE OF DEATH Month Feb. Day 8, Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) yrs 75
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME James T. Pryor		14. MOTHER'S MAIDEN NAME Ardell C. Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219 48 1322	
17. INFORMANT Wilton E. Watts Sr.		Address Same as #2 (husband)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Hemorrhage DUE TO (b) Hypertensive arteriosclerotic DUE TO Vascular disease (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1955 , to 8 Feb, 1967 , that (I) (we) last saw the deceased alive on 8 Feb 1967 , and that death occurred at 9:42 PM , from causes and on the date stated above.			
22a. SIGNATURE John Kehoe		22b. DATE SIGNED 2/8/67	
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS 6300 Riverdale Rd. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 2/11/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pr. Geo. Co Md.
24. FUNERAL DIRECTOR L. Karch's Sons, 4739 Balto Ave Hyattsville		25a. REC'D BY REGISTRAR DATE FEB 14 1967	25b. REGISTRAR'S SIGNATURE Charles Reed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #3&11 infor taken from birth cert. 2/16/67 pc									
02664					02659				
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>1 day & 22 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>					d. STREET ADDRESS <u>6223 Fernwood Terrace</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Scott</u> Middle <u>Brent</u> Last <u>Weissman</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, '67</u>		9. AGE (In years last birthday) Yrs. <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cheverly, Pr. Geo. Co.</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Owen Weissman</u>					14. MOTHER'S MAIDEN NAME <u>Gail Barbara Sperber</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>Hyaline membrane disease</u> IMMEDIATE CAUSE (a) DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> , 19 <u>67</u> , to <u>2/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>67</u> , and that death occurred at <u>11:50</u> A.M., from causes and on the date stated above.									
22a. SIGNATURE <u>M. Nim Sherry</u>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 7, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Mohamad Sherry, M.D.</u>					22d. ADDRESS <u>4637 Eastern Ave. Washington, D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>2/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen. Hosp.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cheverly PC Maryland</u>		
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Admin., Cheverly, Maryland</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>FEB 16 1967</u>									

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

VR A15 (4)
20 M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

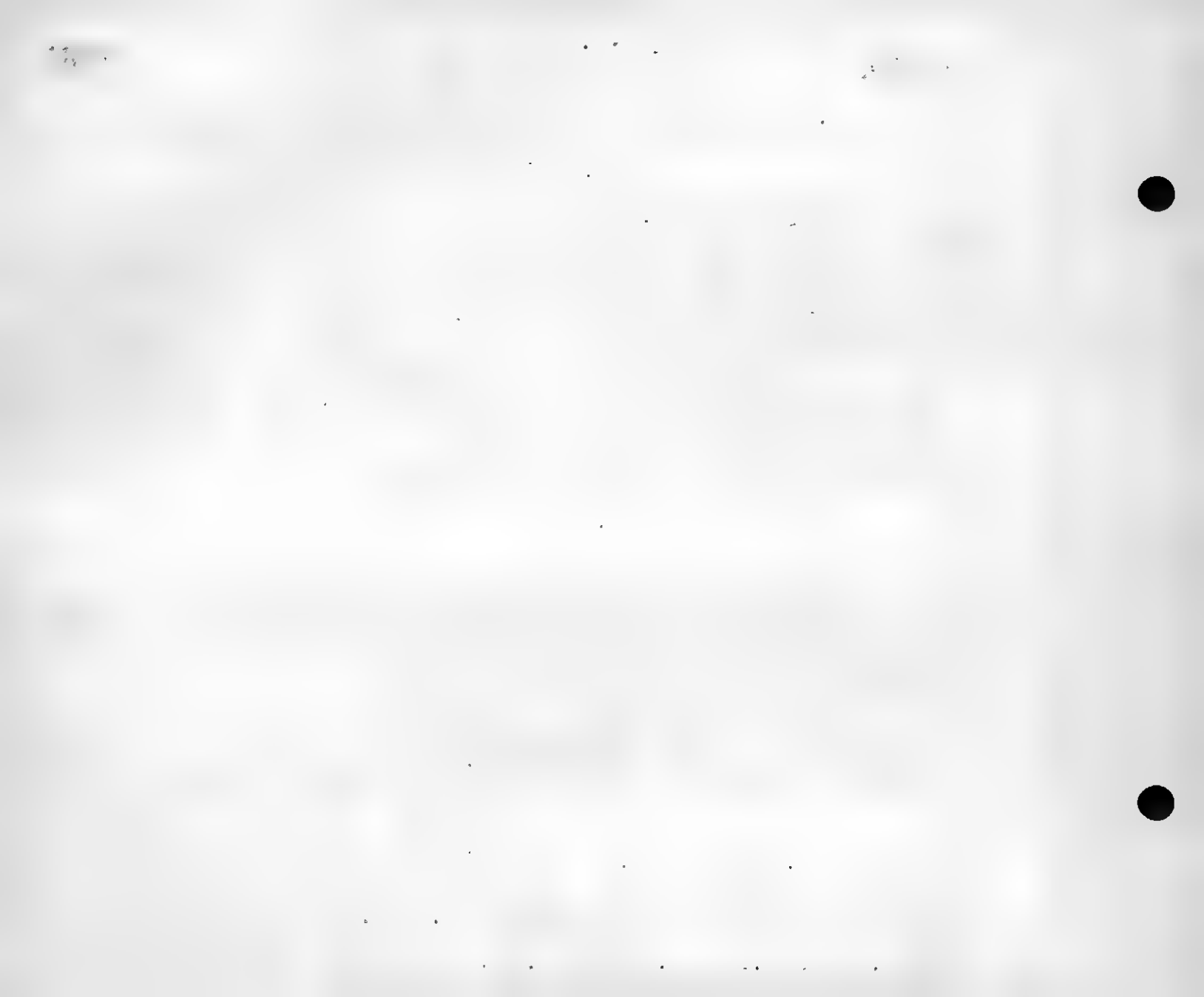
Item #11 info. taken from birth cert.

02665

CERTIFICATE OF DEATH

02661

1. PLACE OF DEATH a. COUNTY Prince George's		b. STATE Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hrs. 10 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3000-76th Ave. Kentland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby		Middle Girl		Last Weston	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1967	
9. AGE (In years last birthday) 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Kentland, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael Wayne Weston				14. MOTHER'S MAIDEN NAME Gloria Jean P. Coley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7625 IMMEDIATE CAUSE (a) Natural Causes DUE TO (b) Immaturity (480 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1967 , to Feb. 28, 1967 , that (I) (we) last saw the deceased alive on Feb. 28, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE John W. Perkins				22b. DATE SIGNED 3-1-67		22c. PHYSICIAN'S NAME (Type) John W. Perkins, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3/4/67		23c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp.	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02666

Item #11 infor. taken from birth cert.

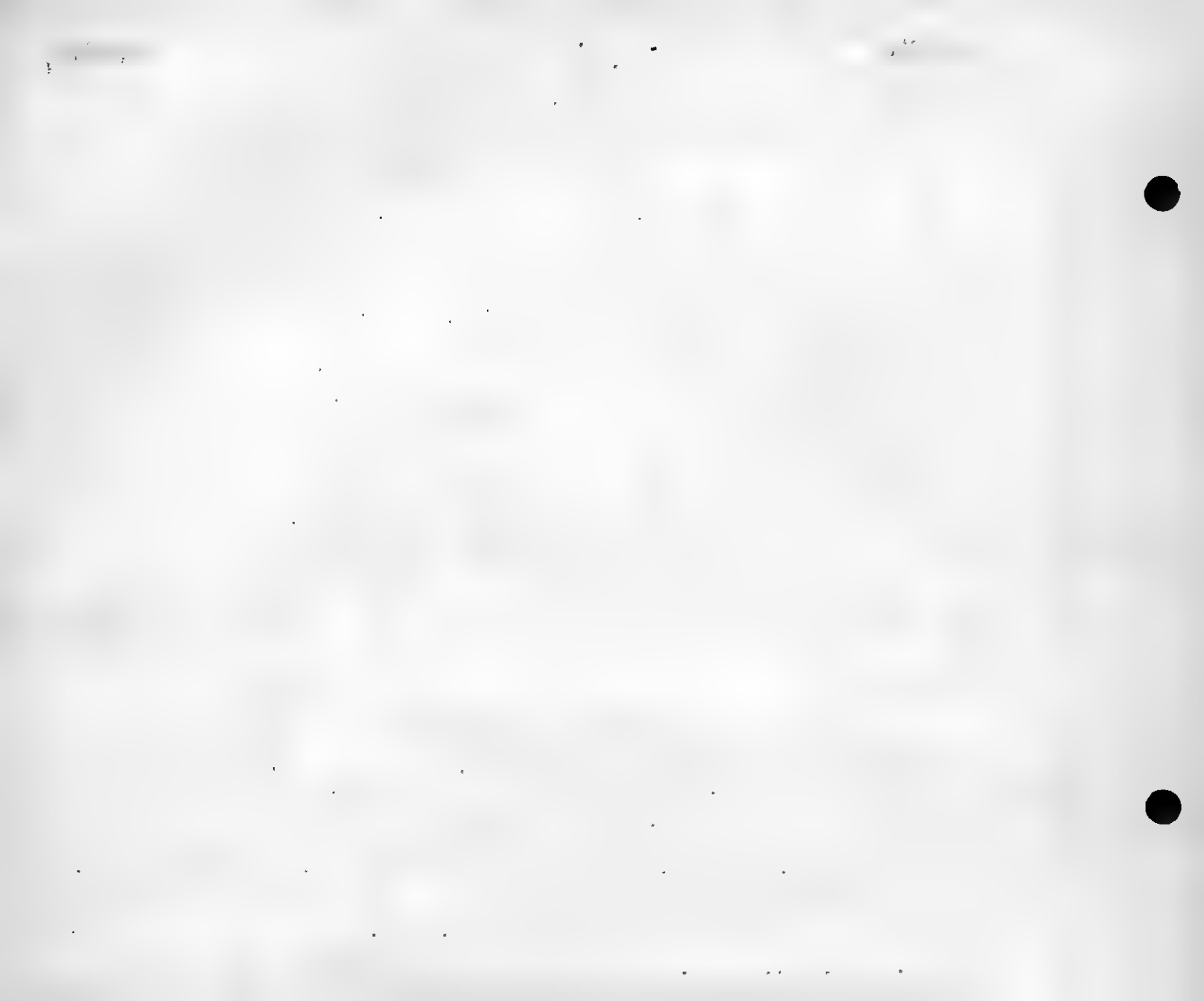
CERTIFICATE OF DEATH

02662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 1 day		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a Maryland b Prince George's	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e STREET ADDRESS 5401 - 56th Place		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Baby Middle Boy "B" Last Wetklow		4 DATE OF DEATH Month Feb. Day 27 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 26, 67	9 AGE (In years last birthday) yrs. 1-1/3	IF UNDER 1 YEAR Months 1 Days 1 Hours 3 Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Cheverly, Md.	
13 FATHER'S NAME David Russell Wetklow		14 MOTHER'S MAIDEN NAME Sherie Lynn Darneille			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17 INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7/16X Prematurity DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH B.W. 2-7 lb
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 26, 1967 , to FEB. 27, 1967 , that (I) (we) last saw the deceased alive on FEB. 27, 1967 , and that death occurred at 11:50 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>Milos A. Jansa</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-28-67	
22c. PHYSICIAN'S NAME (Type) Milos A. Jansa, M.D.		22d ADDRESS 7403 Varnum St. Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF 3/4/67	23c NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp.	23d LOCATION (City or Town) Cheverly	(County) PG	(State) Maryland
24 FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland		25a REC'D BY REGISTRAR MAR 7 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02663

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
c. LENGTH OF STAY IN 1b DOA		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Rt. 1, Box 415, Piscataway Rd.	
3 NAME OF DECEASED (Type or print) Robert Lyna n Willett		4 DATE OF DEATH Month 2 Day 19 Year 1967	
5 SEX MALE	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 May 1888
9. AGE (In years lost birthday) yrs 78		IF UNDER 1 YEAR Months Days Hours Min	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11 BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME CHARLES L. WILLETT	
14 MOTHER'S M A D E N NAME CHRISTINE PICKERALL		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.) NO	
16 SOCIAL SECURITY NO 215-56-9249		17 INFORMANT BADEN UNKLE, Rt 2 Box 415, CLINTON, MD	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22 DATE SIGNED 2-20-67	
EXAMINER'S NAME (Type) John Kehoe M.D.		23a. LOCATION (City or Town) (County) (State) Accokeek P.G. MD.	
23b. DATE THEREOF 2-22-67		23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH Cem.	
23d. LOCATION (City or Town) (County) (State) WALDORF, MD.		23e. RECORD BY REGISTRAR 2-24-1967	
24 FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.		25 REGISTRAR'S SIGNATURE John Kehoe M.D.	

02668

CERTIFICATE OF DEATH

02664

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USAF Hosp Andrews, Andrews AFB- 1 month		c. LENGTH OF STAY IN 1b 1 month		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hosp Andrews, Andrews AFB, Wash D.C.			d. STREET ADDRESS 4513 Rena Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) John Wesley P. Willix			4. DATE OF DEATH Month Feb Day 4 Year 19 67		
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 22 Nov 1917	9 AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USJA, OCCUPATION (Give kind of work done during most of work life, even if retired) U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Garden County, Georgia	
13 FATHER'S NAME James David Willix			14. MOTHER'S MAIDEN NAME Rosa Wilkins		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk to May 65 254-12-9633		17. INFORMANT Rosa Bandy (Mother), Calhoun, Georgia	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Increased intracranial pressure. DUE TO (b) Glioblastoma multiforme DUE TO (c) 18 months					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JUNE , 19 66 , to 4 Feb , 19 67 , that (I) (we) last saw the deceased alive on 3 Feb , 19 67 , and that death occurred at 7:00 A M, from causes and on the date stated above.					
22a. SIGNATURE <i>Charles Judge</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4 Feb 67		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/7/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Wilhelm Funeral ADDRESS Home 4308 Suitland Rd. Suitland, Maryland			25a. REC'D BY REGISTRAR DATE FEB 7 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02669

02665

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1/2 mile north of Seabrook Rd. Crossing		d. STREET ADDRESS 1101 7th. Street, S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Willie Winslow		4. DATE OF DEATH Month Day Year 2 16 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-1946
9. AGE (in years lost birthday) yrs 20		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William N. Winslow		14. MOTHER'S MAIDEN NAME Lillian Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT William Winslow-1421 South Car. Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Decerebration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by train	
20c. TIME OF INJURY Month Day Year Hour a.m. AM pm 2-16- 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) 1/2 mile north of Seabrook Rd. Crossing,		20f. (City or town) (County) (State) Lanham, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 2-17-67	
EXAMINER'S NAME (Type)		Address (Street city town or county)	
23a. BURIAL CREATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.		25a. REC'D BY REGISTRAR DATE FEB 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>Item 1</div> <div>1E 385 2-2-67</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> </div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>02670</div> <div>CERTIFICATE OF DEATH</div> <div>02666</div>									
1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DELAWARE b. COUNTY KENT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOVER 234 SOUTH GOVERNOR BLVD. d. STREET ADDRESS BLVD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Middle Last HARRY FORREST WOODWORTH III					4. DATE OF DEATH Month Day Year FEBRUARY 9 19 67				
5 SEX MALE		6 COLOR OR RACE CAUCASIAN		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 20 JUN 64		9. AGE (n years lost birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A			10b. KIND OF BUSINESS OR INDUSTRY N/A		11 BIRTHPLACE (County & State or foreign country) TRAVIS AFB, CALIF.			12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME HARRY FORREST WOODWORTH, JR.					14. MOTHER'S MAIDEN NAME JUDY ARDEAN BANKS				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO N/A		17 INFORMANT Address HARRY F WOODWORTH JR-FATHER-SAME AS #2				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Disseminated suppurative Staphylococcus aureus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Respiratory acidosis</u> (Conjugase positive) (c) <u>Respiratory acidosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs	
19 WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX this hospital attended the deceased from <u>2/8</u> , 19 <u>67</u> , to <u>2/9</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/9</u> , 19 <u>67</u> , and that death occurred at <u>1:30 A.M.</u> , from causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i> 22c. PHYSICIAN'S NAME (Type) ROGER E. SPITZER, CAPT, USAF, MC						22b. DATE SIGNED 2/9/67		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/67		23c. NAME OF CEMETERY OR CREMATORY Sorbers Cemetery			23d. LOCATION (City or Town) (County) (State) Reyburn, Pennsylvania		
24. FUNERAL DIRECTOR ADDRESS Jos. Gawler's Sons, Inc., Washington, DC				25a. REC'D BY REGISTRAR FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

10-10-10

10-10-10



10-10-10

10-10-10



02671

CERTIFICATE OF DEATH

02667

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>				e. STREET ADDRESS <u>Timber Lane</u> <u>4608 Disbarbaria Lane</u>			
3. NAME OF DECEASED (Type or print) <u>William Louis Wubbena</u>				4. DATE OF DEATH <u>February 7 1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5, 1894</u>	9. AGE (In years last birthday) yrs. <u>73</u>	10. F UNDER 1 YEAR Months Days		11. I UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <u>Ret. transportation specialist U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Standish, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jan Wubbena</u>			
14. MOTHER'S MAIDEN NAME <u>Catharina Jungjohann</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>			
16. SOCIAL SECURITY NO. <u>700-01-6403</u>				17. INFORMANT <u>Mande M. Wubbena</u> Address <u>4608 Timber Lane Lanham, Maryland</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary arteriosclerosis</u> DUE TO (c) <u>4 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old dysrhythmic infarction - 1963</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August, 1958</u> , to <u>Jan. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17, 1967</u> , and that death occurred at <u>1801 Eye St. N.W.</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Alban W. Rager</u>				22b. DATE SIGNED <u>2/8/1967</u>		22c. PHYSICIAN'S NAME (Type) <u>ALBAN W. RAGER</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	
23d. LOCATION (City or Town) <u>Arlington, Virginia</u>				23e. REC'D BY REGISTRAR <u>Feb 1 - 1967</u>		23f. REGISTRAR'S SIGNATURE <u>James Judge</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Humphrey, Inc.</u>				25. ADDRESS <u>8434 Ga. Avenue Silver Spring, Md.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11, 12, 13, 14 Film 6386 3/6/67 mh

02672

CERTIFICATE OF DEATH

02668

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PR. GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
c. LENGTH OF STAY IN lb <u>13 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PR. Geo. Genl. Hospital</u>		d. STREET ADDRESS <u>Bowie, MD.</u>	
3. NAME OF DECEASED (Type or print) <u>James</u> First Middle Last <u>Young G.</u>		4. DATE OF DEATH <u>Feb. 26</u> Month Day Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>-----1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO (b) <u>CARCINOMA OF THE LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (t) (this hospital) attended the deceased from <u>Feb. 13</u> , 1967, to <u>Feb. 26</u> , 1967, that (t) (we) last saw the deceased alive on <u>Feb. 26</u> , 1967, and that death occurred at <u>1:40 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman K. Bohrer</u> M.D.		22b. DATE SIGNED <u>Feb. 27, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman K. Bohrer, M.D.</u>		22d. ADDRESS <u>Prince George's General Hospital</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hormony Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co., Md.</u>
24. FUNERAL DIRECTOR <u>Lalney Funeral Home</u> ADDRESS <u>3831 La Ave NW</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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07250

5050

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02673

CERTIFICATE OF DEATH

02669

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5001 Riverdale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Josephine B. Zier			4. DATE OF DEATH Month Day Year Feb. 19 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7 Nov., 1897		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during last week, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Henry Bloser			14. MOTHER'S MAIDEN NAME Mary E. Fox		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. Jacob H. Zier Same as #2 (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 Congestive heart failure DUE TO (b) Arrtrial fibrillation DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/4 , 19 67 , to 2/19 , 19 67 , that (I) (we) last saw the deceased alive on 2/18 , 19 67 , and that death occurred at 5.05 AM from causes and on the date stated above.					
22a. SIGNATURE Julius Kauffman			22b. DATE SIGNED 2/19/67		22c. PHYSICIAN'S NAME (Type) Julius Kauffman, M. D.
22d. ADDRESS 6501 Landover Rd. Cheverly, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md.					
24. FUNERAL DIRECTOR Francis Harcho Sons Hyattsville, Md			25a. REC'D BY REGISTRAR DATE FEB 23 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]

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03820

03820

1. The first part of the report is a general description of the project.

2. The second part is a description of the methodology used.

3. The third part is a description of the results.

4. The fourth part is a description of the conclusions.

5. The fifth part is a description of the future work.

6. The sixth part is a description of the references.

7. The seventh part is a description of the appendix.

8. The eighth part is a description of the bibliography.

9. The ninth part is a description of the glossary.

10. The tenth part is a description of the index.

11. The eleventh part is a description of the list of figures.

12. The twelfth part is a description of the list of tables.

13. The thirteenth part is a description of the list of abbreviations.

14. The fourteenth part is a description of the list of symbols.

15. The fifteenth part is a description of the list of acronyms.

16. The sixteenth part is a description of the list of terms.

17. The seventeenth part is a description of the list of definitions.

18. The eighteenth part is a description of the list of examples.

19. The nineteenth part is a description of the list of exercises.

20. The twentieth part is a description of the list of problems.

21. The twenty-first part is a description of the list of projects.

22. The twenty-second part is a description of the list of assignments.

23. The twenty-third part is a description of the list of tests.

24. The twenty-fourth part is a description of the list of quizzes.

25. The twenty-fifth part is a description of the list of exams.

26. The twenty-sixth part is a description of the list of papers.

27. The twenty-seventh part is a description of the list of theses.

28. The twenty-eighth part is a description of the list of dissertations.

29. The twenty-ninth part is a description of the list of books.

30. The thirtieth part is a description of the list of journals.

31. The thirty-first part is a description of the list of magazines.

32. The thirty-second part is a description of the list of newspapers.

33. The thirty-third part is a description of the list of websites.

34. The thirty-fourth part is a description of the list of videos.

35. The thirty-fifth part is a description of the list of audio files.